

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Chella U. Abbot			2a. DATE OF DEATH MONTH DAY YEAR 1 23 84		2b. HOUR 9 4 M		
3. SEX Female ? F		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 5 87		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 4916 Anntana Ave 21206		14. FATHER'S NAME FIRST MIDDLE LAST Richard F Underwood		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leona M Lyman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 189-26-1990		17. INFORMANT Miss Jessie U Abbot		ADDRESS Same As 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 0389 IMMEDIATE CAUSE (a) Cardio pulmon ary arrest DUE TO, OR AS A CONSEQUENCE OF (b) sepsis DUE TO, OR AS A CONSEQUENCE OF (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/22, 19 84, to 1/23, 19 84, that (I) (we) last saw the deceased alive on 1/23, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John Joyce MD		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Joyce MD		22e. ADDRESS Balto City Hsp. Balto MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/28/84		23c. NAME OF CEMETERY OR CREMATORY Forty Fort		23d. LOCATION CITY OR TOWN COUNTY STATE Forty Fort Penna	
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland				25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 24 1984			

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 6 8 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARTHUR ABRAHAM			2a. DATE OF DEATH MONTH DAY YEAR 1 30 84			2b. HOUR 2:00 AM	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 12 31 06		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Balt.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinac Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) lawyer		12b. KIND OF BUSINESS OR INDUSTRY law	
13a. STATE MD				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST JACOB ABRAHAM				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JULIA GOLDSCHMIDT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 116-07-8722		17. INFORMANT ADDRESS MRS. EVELYN N. ABRAHAM APT. 7E 3623 GLENGYLE AVE. BALTO., MD 21215			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **cardiovascular collapse**
1889
DUE TO, OR AS A CONSEQUENCE OF
(b) **Bladder Ca**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from 1/29 , 19 84 , to 1/30 , 19 84 , that (I) (we) lost saw the deceased alive on 1/30 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. Ford MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/30/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Ford				22e. ADDRESS Belvedere & Greeneping Ave.			

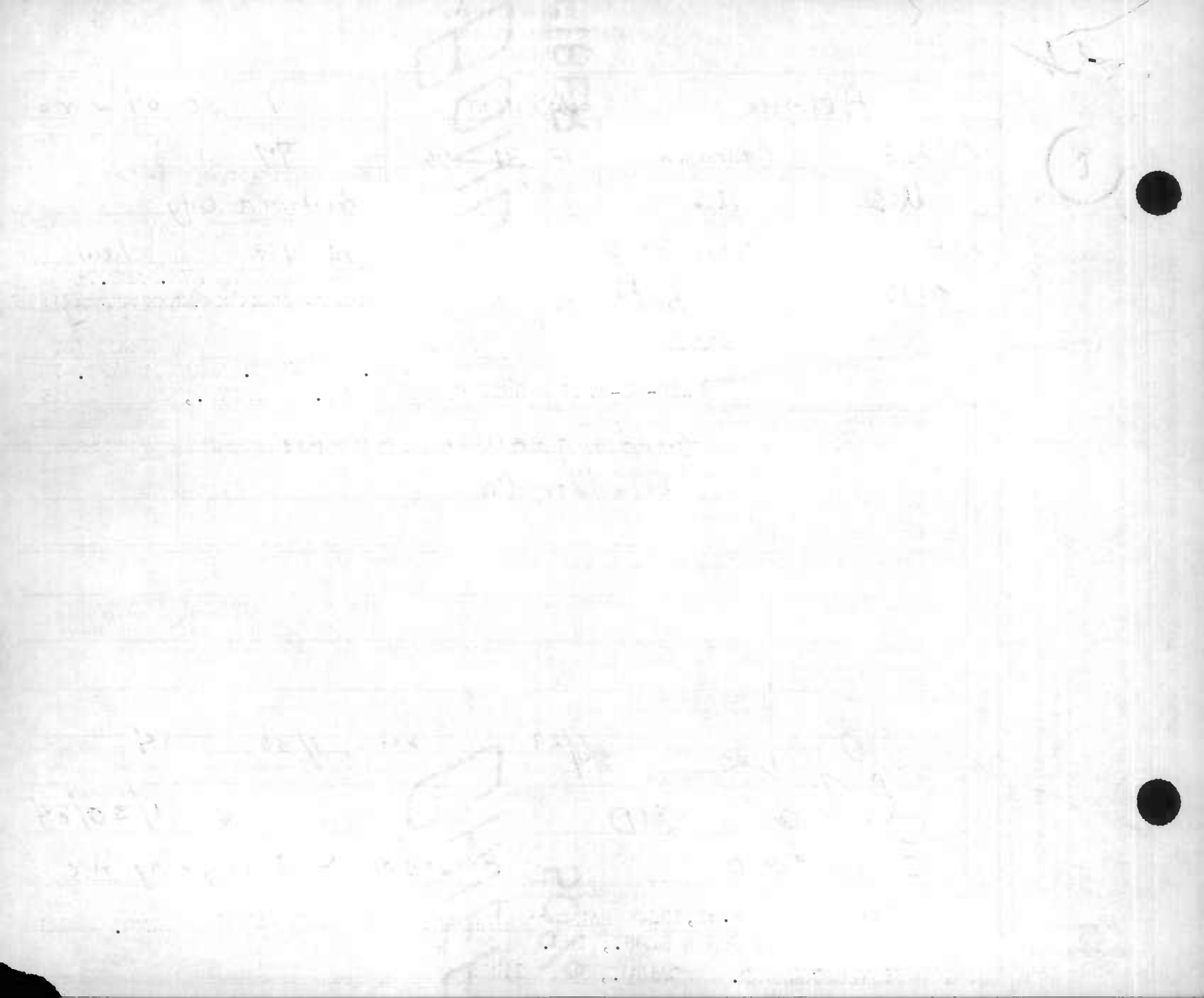
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 31, 1984		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW		23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN BALTO. MD	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.				25. DATE REC'D. BY REGISTRAR FEB 1 1984			
6010 REISTERSTOWN RD. BALTO., MD 21215				REGISTRAR'S SIGNATURE John J. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Helen Bitler Adams			2a. DATE OF DEATH MONTH DAY YEAR January 22, 1984		2b. HOUR 10 P.M.	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 2, 1903		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long Green Nursing Home		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Nursing				
13a. STATE Maryland		13b. COUNTY ----		13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST J. Howard Bitler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally A Boyer		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-03-2602D		17. INFORMANT ADDRESS John Rolker 14 W. Saratoga St. 21201		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) Generalized atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from May 5, 1978 to Jan 22, 1984 , that (I) (we) last saw the deceased alive on Jan 19, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE William F. Fritz		DEGREE Attending Physician		22c. DATE SIGNED 1/23/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William F. Fritz		22e. ADDRESS 2 W. University Pkwy.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1--26--84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld		ADDRESS Home 6500 York Road Bal.Md		25a. DATE REC'D. BY REGISTRAR JAN 21 1984		
				25b. REGISTRAR'S SIGNATURE John J. Conner		

BP

RECEIVED

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) NELLIE L AINSWORTH			2a. DATE OF DEATH MONTH DAY YEAR 1 25 84			2b. HOUR 12:30 P M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 19, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KESWICK				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Advertisement		
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 108 W 39th Street Apt 34 21210	
14. FATHER'S NAME FIRST MIDDLE LAST Cyrus Wilson Long			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Lippy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 26 2152		17. INFORMANT ADDRESS William M. Ainsworth Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis with Senile Dementia 4370 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 6 yrs									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10 April 1984 to 25 Jan 1984, that (I) (we) last saw the deceased alive on 25 Jan 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Dr. Richardson			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 25 JAN 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Richardson			22e. ADDRESS The Keswick Baltimore, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/27/84		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial			23d. LOCATION CITY OR TOWN COUNTY STATE Towson, Balto. Co., Md.		
24. FUNERAL DIRECTOR NAME Burgee Funeral Home, P.A.					ADDRESS 21211		25a. DATE REC'D. BY REGISTRAR JAN 26 1984		25b. REGISTRAR'S SIGNATURE Johnston	

1. The medical examiner must be notified at once.

MEDICAL CERTIFICATION

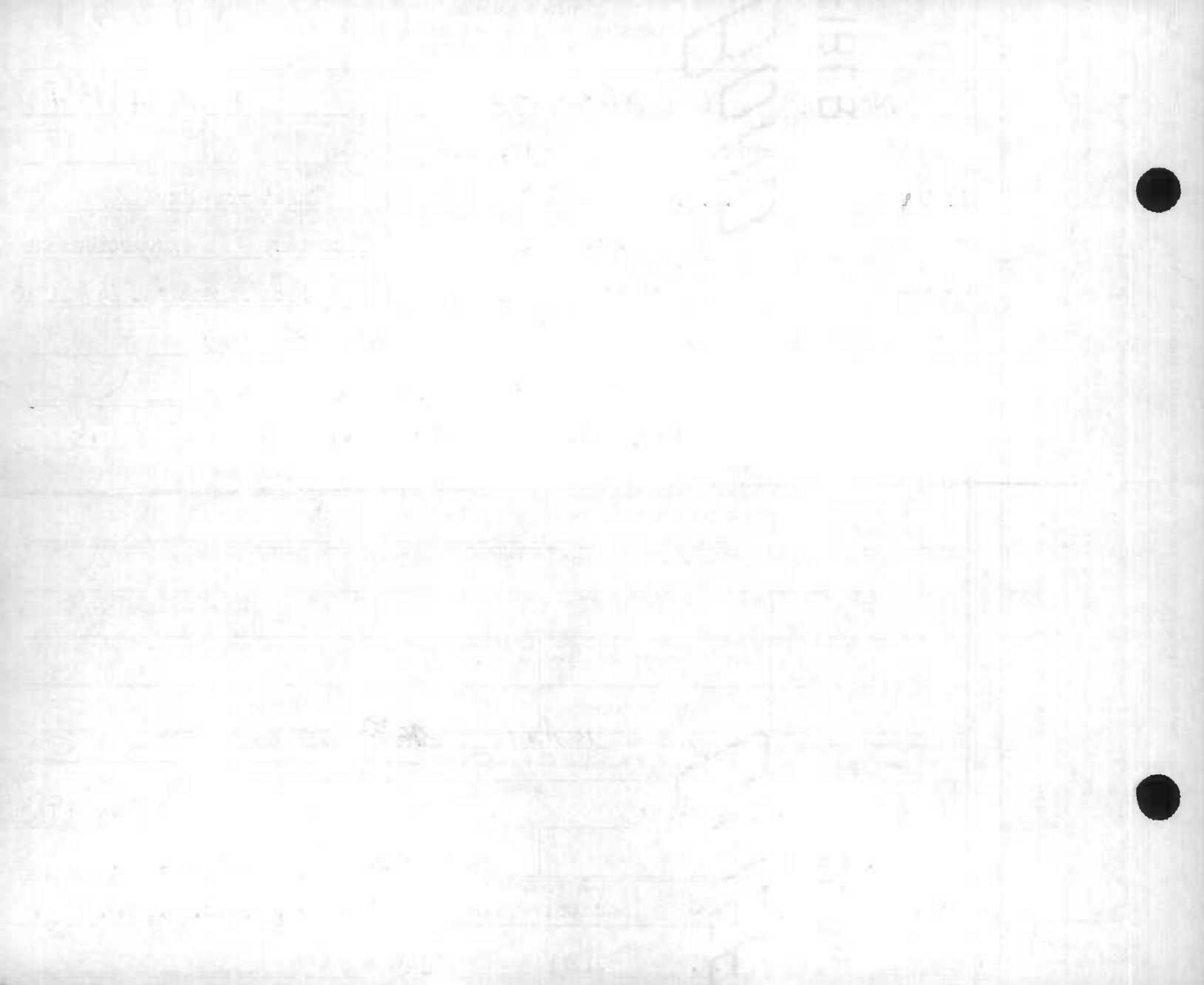
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

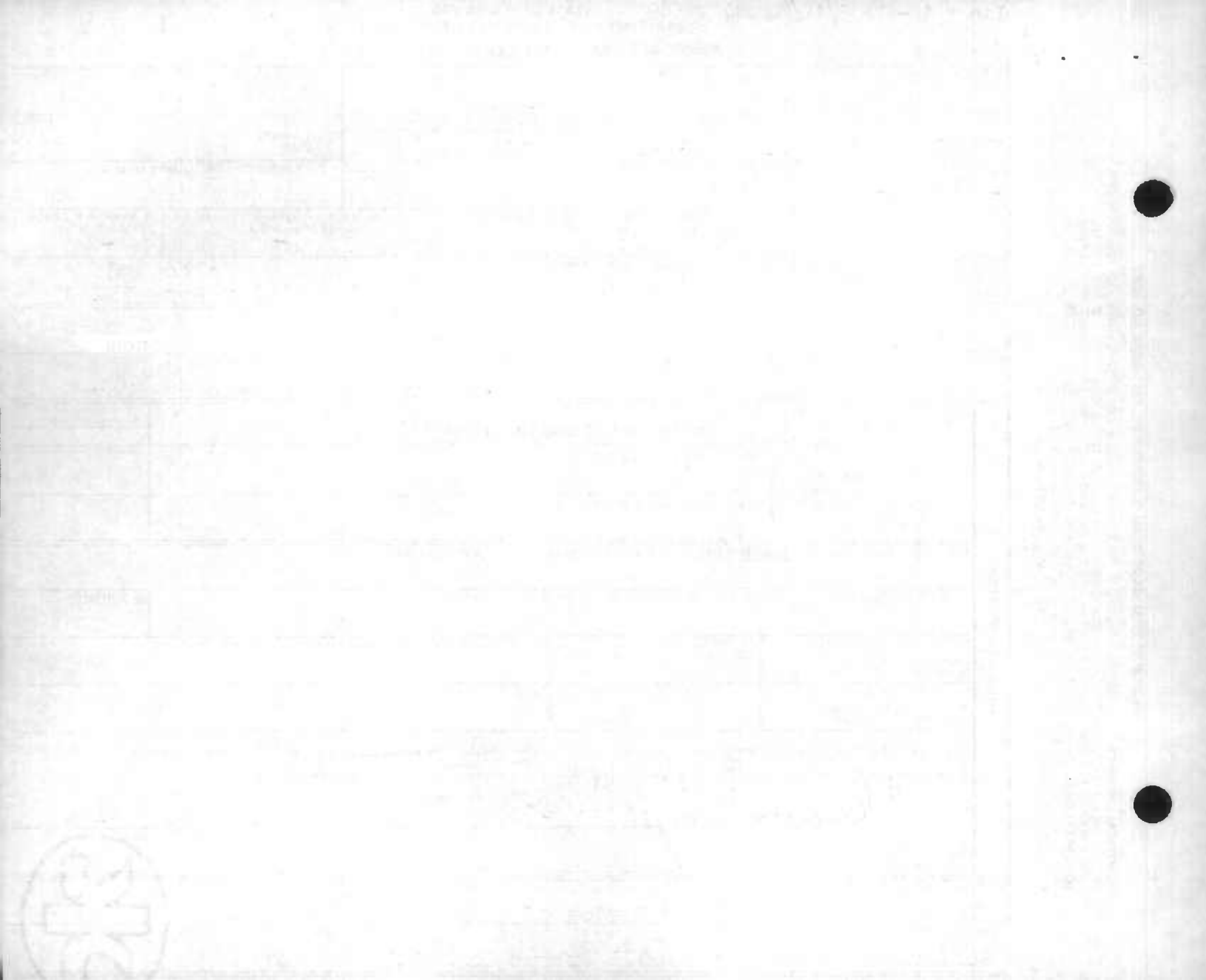
LIBRARY

1000



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
Michelle E. Akonom						MATED <input checked="" type="checkbox"/>		1-21 1984		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
Female	White	Sept. 8, 1982	1 YRS.	16		1-21 1984		10:08		P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Baltimore, MD.		USA				Baltimore City, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		3342 Elmley Avenue									
13a. STATE						13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.								Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
Michael Akonom						Margaret Benvengi					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
						Margaret Akonom, same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Acute and Chronic Bronchitis</u>											
4919 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) _____ DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION					
						STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Dennis F. Smyth</u>						TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 1-22-84	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.						ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial				1/25/84		Garden of Faith		Balto, Md.			
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Schimunek Funeral Home, 3331 Brehms La,						JAN 24 1984					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 6 9 3

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST KATIE T. ALEXANDER		MONTH DAY YEAR 1-6-84	
3. SEX		2b. HOUR	
FEMALE		4:45p M	
4. RACE		6. AGE (IN YEARS LAST BIRTHDAY)	
BLACK		85 YRS.	
5. DATE OF BIRTH		IF UNDER 1 YEAR	
MONTH DAY YEAR 10-18-1898		MONTHS DAYS	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Va.		9. BALTIMORE CITY OR COUNTY OF DEATH	
7b. CITIZEN OF WHAT COUNTRY?		Baltimore City MD	
U.S.A.		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
10. CITY OR TOWN OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		Homemaker At home	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. INSIDE CITY LIMITS?	
LUTHERAN HOSPITAL		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STREET ADDRESS	
13a. STATE		1550 Winford Rd. 21239	
13b. COUNTY		15. MOTHER'S MAIDEN NAME	
Md.		FIRST MIDDLE LAST Katie Marys	
14. FATHER'S NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
FIRST MIDDLE LAST George Parham		(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO.		17. INFORMANT	
218-10-7782		ADDRESS Rev. C.C. Alexander 3723 Woodbine Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Liver tumor.			
2390			
DUE TO, OR AS A CONSEQUENCE OF			
(b) POSSIBLE sepsis.			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		20a. AUTOPSY?	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-26-1983 to 1-6-1984, that (I) (we) lost saw the deceased alive on 1-6-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		22c. DATE SIGNED	
Matthew		1/6/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
A. Mathew		Lutheran Hospital Ashburton Ave Baltimore	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		1-11-84	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Baltimore Cemetery		Baltimore Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Randolph J. Collick 24316 Oliver St.		JAN 9 1984	
25b. REGISTRAR'S SIGNATURE			
John J. Canine			

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

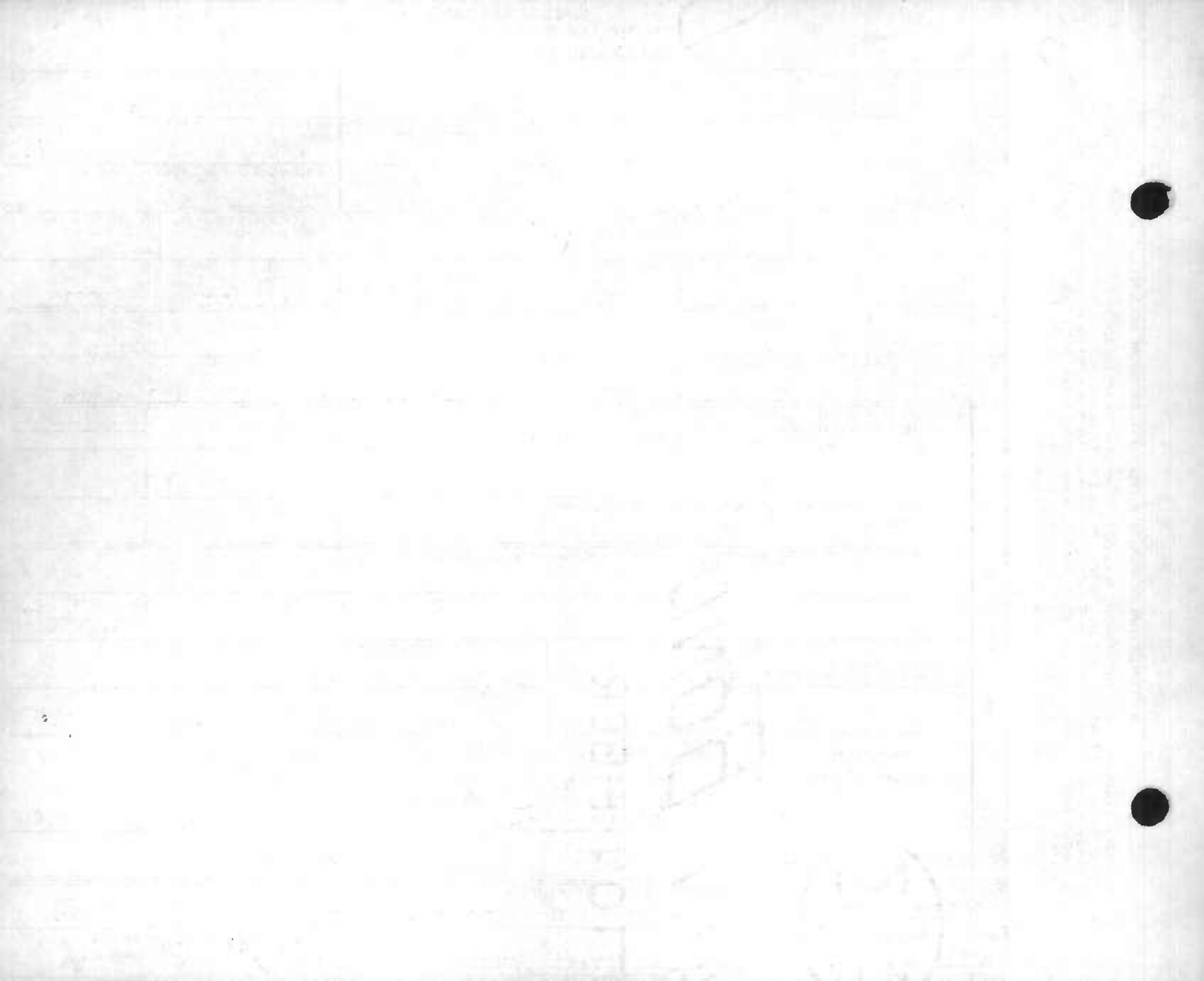
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH				2b. HOUR			
Melvin C. Alford								XX MONTH DAY YEAR 1-16 19 84				2:30 a. M.			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				2d. HOUR	
Male	Black	10 5 63		20 YRS.						1-16 19 84				a. M.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.								Baltimore City, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		2256 Cecil Avenue													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2256 Cecil Avenue				21218			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST Dozier B. Alford				FIRST MIDDLE LAST Wilma L. Gooden											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS							
(YES, NO, OR UNKNOWN) UNKNOWN		(IF YES, GIVE WAR OR DATES) N/A		Dozier B. Alford				2256 Cecil Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Gunshot Wound of Head (unspecified)															
9554															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c) DUE TO, OR AS A CONSEQUENCE OF															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												(head only) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				6:00xx 1-14 19 84				subject shot himself							
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				Home				2256 Cecil Avenue, Balto., Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
Dennis F. Smyth, M.D.				Assistant				1-16-84							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Dennis F. Smyth, M.D.				111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
BURIAL				1/20/84		Garris on Forest VA CEM				Owing Mills, COUNTY STATE					
										Md.					
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR				REGISTRAR'S SIGNATURE					
NAME ADDRESS William C. March F/H Inc. 1101 E North Avenue						JAN 17 1984				John J. Coniff					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 5 9 5

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALEXANDER E ALLEN			2a. DATE OF DEATH MONTH DAY YEAR 01 31 1984			2b. HOUR 3:00P	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 13 12		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 924 Bentalou Street 21216							
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Allen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Brown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) UNKNOWN		16b. SOCIAL SECURITY NO. 218-07-0561		17. INFORMANT ADDRESS Elizabeth F. Allen 924 Bentalou Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4442 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal Failure, Pneumonia, Stroke DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION 1/25 Thrombectomy		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Clot Communfered artery		19c. ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/31 19 84 to 1/31/84 19 84 , that (I) (we) last saw the deceased alive on 1/31 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/31/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature]		22e. ADDRESS Johns Hopkins Hospital					
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 2/6/84		23c. NAME OF CEMETERY OR CREMATORY Md. National Mem Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc, 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR FEB 2 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#1, per F.H. 1/ 27/84 kam

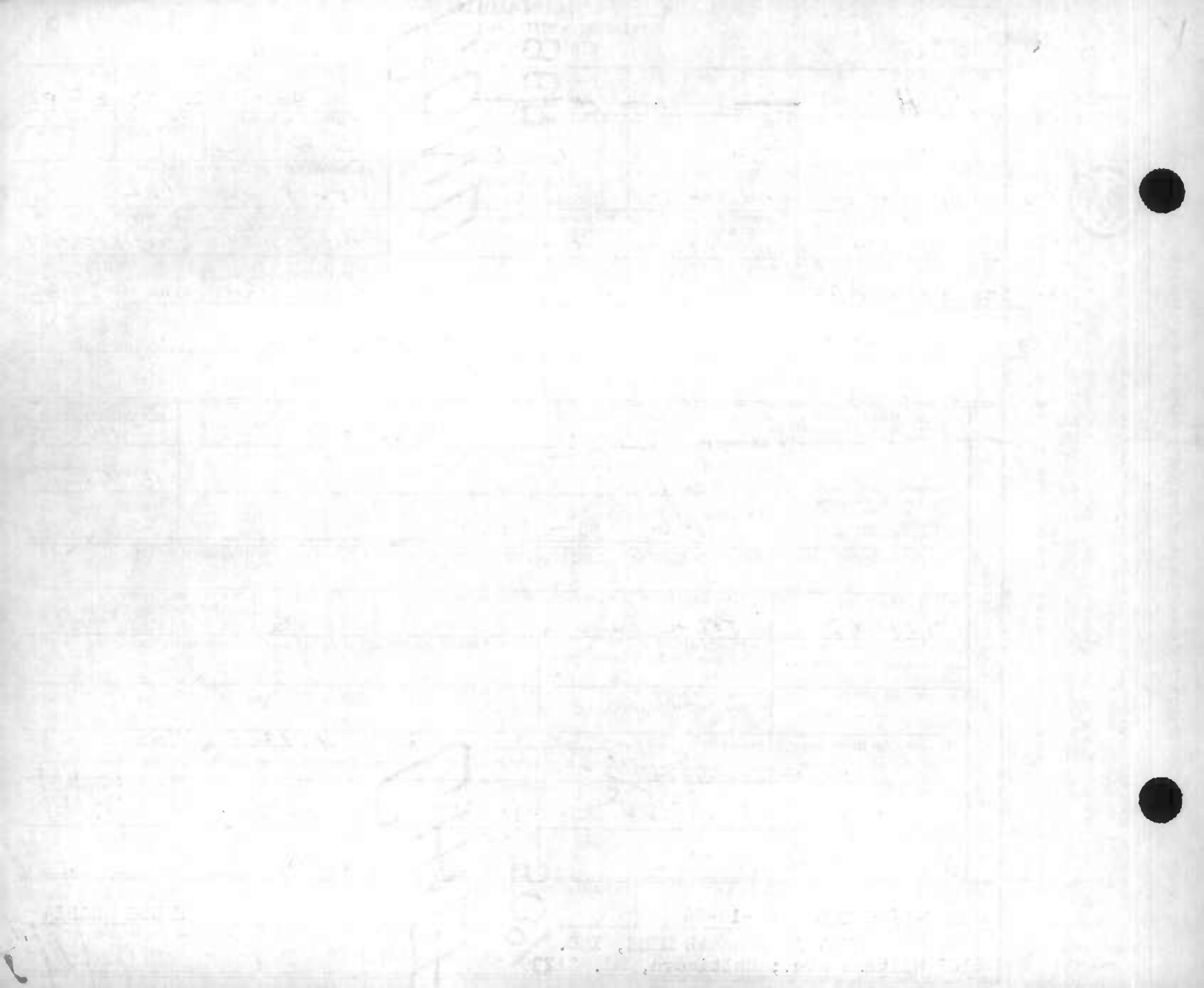
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 6 9 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SALEM		FIRST A	MIDDLE COL	LAST Al-Mahmoud	2a. DATE OF DEATH MONTH DAY YEAR JAN 12 84		2b. HOUR 6²⁰ P.M.		
3. SEX M		4. RACE ARABIC		5. DATE OF BIRTH MONTH DAY YEAR 1 1 28		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SAUDI ARABIA		7b. CITIZEN OF WHAT COUNTRY? SAUDI ARABIA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Balto. City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MILITARY		12b. KIND OF BUSINESS OR INDUSTRY MILITARY	
13a. STATE WASH. D.C.				13b. CITY OR TOWN WASH. D.C.		13c. STREET ADDRESS / ZIP CODE 2109 E STREET N.W. 20037			
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS Chart in hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 5860 IMMEDIATE CAUSE (a) A Cardiovascular Collapse								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Hours	
DUE TO, OR AS A CONSEQUENCE OF (b) sepsis DUE TO, OR AS A CONSEQUENCE OF (c) renal transplant								16 Hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION 12/19/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Renal Failure				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/19/83 to 1/12/84 , that (I) (we) last saw the deceased alive on 1/14/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Marc B. Applestein				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/12/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marc B. Applestein				22e. ADDRESS C/O UNIV. Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL/BURIAL		23b. DATE 01-14-84		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE SAUDI ARABIA			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.						25a. DATE REC'D. BY REGISTRAR JAN 17 1984		25b. REGISTRAR'S SIGNATURE John E. Carney	
4107 Wilkens Ave.; Baltimore, Md. 21229									



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 000697

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GERTRUDE ALPERT			2a. DATE OF DEATH MONTH DAY YEAR 01-19-84			2b. HOUR 12³⁰ P.M.				
3. SEX F FEMALE		4. RACE WHITE		5. DATE OF BIRTH DAY MONTH YEAR 05 1909 08 XXXXXXXX		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto City MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY ATHOME		
13a. STATE MARYLAND			13b. COUNTY BALTO.		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 610 GLENROCK RD. #21208	
14. FATHER'S NAME FIRST MIDDLE LAST MAX ADDIS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH ZENZEL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 212-74-5021		17. INFORMANT MR. WILLIAM JAMES KAPLAN APT. C 3010 NORTHBROOK RD. BALTO., MD 21209				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4149
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **ischemic heart disease**

DUE TO, OR AS A CONSEQUENCE OF

(c) **ASCVD**

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 01-19-84 to 01-19-84 , that (I) (we) lost the deceased alive on 01-19-84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE B. ZAN-WIN		DEGREE		22c. DATE SIGNED 01-19-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. ZAN-WIN		22e. ADDRESS Levinale Geriatric CR 21215		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 20, 1984		23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MEN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
---	--	--------------------------------	--	--	--	---	--

24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21214			25a. DATE REC'D. BY REGISTRAR JAN 26 1984		25b. REGISTRAR'S SIGNATURE John J. Conner	
--	--	--	--	--	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

2. $\frac{1}{2} \sqrt{2}$ 3. $\frac{1}{2} \sqrt{2}$ 4. $\frac{1}{2} \sqrt{2}$

• • •

• • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be retained until 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified and a separate report filed.

8

1- FOR
STATE
REGISTRAR

EDUARDA ALVAREZ

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Eduarda B Alvarez			2a. DATE OF DEATH MONTH DAY YEAR January 27th 84			2b. HOUR 0330 A.M.			
3. SEX Female		4. RACE Asian		5. DATE OF BIRTH MONTH DAY YEAR 10 13 31		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Philippines		7b. CITIZENSHIP OF WHAT COUNTRY? Philippines		8. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Health Care	
13a. STATE MD		13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6997 Deep Cup Road 6977 Deep Cup Rd. 21045	
14. FATHER'S NAME FIRST LAST Marciano Guansing			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Natividad Narcida						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217 943122		17. INFORMANT Dolores Hijada		ADDRESS Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Cardiogenic shock DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/26, 19 84, to 1/27, 19 84, that (I) (we) last saw the deceased alive on 1/27, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Deborah Zimmerman MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/27/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Deborah Zimmerman						22e. ADDRESS 22 S Greene St.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 1984		23c. NAME OF CEMETERY OR CREMATORY LaLoma Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Quezon City Philippines		
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 5555 Twin Knolls Road, Columbia, Maryland 21045						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE John J. Carroll			

BP

LARRY & BERNICE C. WITZKE Funeral Home P.A.
2745 N. Lincoln Ave., Chicago, Ill. 60642

1. The first step is to identify the key components of the system. This involves understanding the hardware, software, and data involved in the process.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		JAN 4, 1984		8 ³⁰ A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
F		W		MONTH DAY YEAR 5-10-1900		83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Balto. City		U.S.A.		Balto. City		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTO CITY		MFL Nursing Home - BCH		Dietian-Retired		Women's Hosp.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.				Baltol		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		4320 Clareway Apt. 7 P		MAY 83	
Thomas Huth		Louise Schmidt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		214-14-8805		Joseph G. Annhein -		4501 Antanna Ave-21206	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - Biliary tract/Pancreas</u> 1569 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>26 Jul</u> 19 <u>83</u> , to <u>4 Jan</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3 Jan 84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Edmunds Beacham MD		22c. DATE SIGNED 4 Jan 84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
R. G. BEACHAM M.D.		Baltimore City Hospitals, Md.		Burial		1-6-84	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John C. Miller Inc-6415 Belair Rd.-21206		JAN 5 1984		John C. Miller			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

WILKINSON

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <u>Ethel J. Anderson</u>						2a. DATE OF DEATH MONTH DAY YEAR <u>1-6-84</u>				2b. HOUR <u>12:43 PM</u>	
3. SEX <u>F</u>		4. RACE <u>C. White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>MAR 7, 1905</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>78</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>PENNA.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE CITY</u> MD.					
10. CITY OR TOWN OF DEATH <u>BALTIMORE</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>UNIVERSITY HOSP.</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>TEACHER</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>ELEMENTARY</u>			
13a. STATE <u>PENNA</u>				13b. COUNTY <u>YORK</u>		13c. CITY OR TOWN <u>STEWARTSTOWN</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>12 CHARLES ST. 17363</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>WILLIAM B JENKINS</u>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>LILLIAN SHRODES</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>W.E. JENKINS, 4444 CRACETOWN RD., MD. Pylesville,</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <u>4479</u> IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Presumed aspiration vs massive pulmonary embolus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Unknown</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>45 min</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Severe hypoproteinemia</u>											
19a. DATE OF OPERATION <u>12/18/83</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Angioplasty (2) sup femoral artery (2) below the knee amputation</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I (this hospital) attended the deceased from <u>12/14</u> , 19 <u>83</u> to <u>1/6</u> , 19 <u>84</u> , that I (we) <u>did</u> saw the deceased alive on <u>1/6</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)											
22b. SIGNATURE <u>Maud Hansen, MD</u>				DEGREE <u>Resident</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>1/6/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S.P. Knud-Hansen, MD</u>				22e. ADDRESS <u>22 S. Greene ST, Baltimore, Md 21201</u>							
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>				23b. DATE <u>1/8/84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>STEWARTSTOWN CEM.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>STEWARTSTOWN, YORK PA.</u>			
24. FUNERAL DIRECTOR <u>Kenneth W. Chuburn</u>				25a. DATE REC'D. BY REGISTRAR <u>JAN 11 1984</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 1650M 1/81
 (VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 84 00701	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Jack Anderson						2a. DATE OF DEATH MONTH DAY YEAR 1 8 84		2b. HOUR 10:04 AM	
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 23 39		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt. City MD.					
10. CITY OR TOWN OF DEATH Balt.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Seafood			
13a. STATE Md.		13b. COUNTY Balt		13c. CITY OR TOWN Balt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21223 McHenry St			
14. FATHER'S NAME FIRST MIDDLE LAST Ed Anderson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lovie James							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-36-5804		17. INFORMANT ADDRESS Nellie R. Anderson Baltimore, Md.							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: carcinoma, right lung IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____											
19a. DATE OF OPERATION 02/25/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED carcinoma, right lung				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Feb 18 19 83 to Jan 6 19 84 , that (I) (we) lost saw the deceased alive on Jan 6 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John R. Hankins				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED Jan. 9, 1984			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Hankins, MD				22e. ADDRESS 22 South Greene St, Baltimore MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 10, 84		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE White Marsh Balto. Md.		21201			
24. FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home Hampstead, Md				25a. DATE REC'D. BY REGISTRAR JAN 13 1984		25b. REGISTRAR'S SIGNATURE Joan J. Chief					

BP

10/10/10

10/10/10

X

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Murrell L. Anderson										2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 16 19 84	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1 27 10	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 73 YRS.	IF UNDER 1 YR. IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 16 19 84		2d. HOUR P M 10:24 P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1711 Baker Street 21217			
14. FATHER'S NAME FIRST MIDDLE LAST John W. Anderson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara James							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-09-3420		17. INFORMANT ADDRESS Julia F. Anderson 1711 Baker Street							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (d) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (d) stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Thomas D. Smith, M.D.				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 1/17/84			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/21/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co, Md.			
24. FUNERAL DIRECTOR NAME William C March F/H Inc.				ADDRESS 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR JAN 19 1984		25b. REGISTRAR'S SIGNATURE John J. Connelley	

BP

THE UNIVERSITY OF CHICAGO



[Faint, illegible handwritten text]



[Faint, illegible handwritten text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 / 0 3

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JEANNETTE ELIZABETH ARMSTRONG		2a. DATE OF DEATH MONTH DAY YEAR JANUARY 1 26 84		2b. HOUR 7 p M
3. SEX FEMALE	4. RACE NEGRO	5. BIRTHDAY MONTH DAY YEAR 2 10 1910		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.		10. USUAL OCCUPATION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOMEMAKER		
11. CITY OR TOWN OF DEATH BALTIMORE		12. KIND OF BUSINESS OR INDUSTRY		
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE MARYLAND	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. STREET ADDRESS 1606 DELAND CT 21217	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATIE HEBB		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-12-1249		
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> 4349 DUE TO, OR AS A CONSEQUENCE OF (b) <u>GRAM NEGATIVE SEPSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>CEREBRAL INFARCT</u>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>HYPERGLYCEMIA</u>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21e. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>1/9</u> , 19 <u>84</u> , to <u>1/26</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Edward Wolf MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/26
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD WOLF MD		22e. ADDRESS 6400f Apollo Drive Balt., Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 01/31/84	23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM PARK	
23d. LOCATION (CITY OR TOWN) ARBUTUS BALTO., CO., Md.				
24. FUNERAL DIRECTOR MARSHALL W. JONES, JR. 4101 EDMONDSON AVE., BALTO., Md.: 21229		25a. DATE REC'D. BY REGISTRAR FEB 1 1984		
25b. REGISTRAR'S SIGNATURE John J. Lander				

BP

2



Handwritten vertical text, possibly a date or identifier.

Handwritten vertical text, possibly a date or identifier.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST Martha Patton Arris			MONTH DAY YEAR January 16, 1984		M	
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Female	White	MONTH DAY YEAR 4 19 09		74 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
West Virginia	U.S.A.			BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore	Pinlico Manor Nursing Home		Retired		Restaurant	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
Maryland	-----	Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	111 W. Centre Street 21201		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Anthony Coleman		Susie Blackburn				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
No		213-07-8355	Evelyn Tsakiris 2610 Endman Ave. 21213			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) -----						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: -----						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the doctor) attended the deceased from JAN. 16 1984 to JAN. 16 1984 , that (we) lost saw the deceased alive on JAN. 16 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.		22b. SIGNATURE Dr. Sunshine MD		22c. DATES SIGNED 1/17/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
DR. SUNSHINE, MD		6210 PK Hts Ave BALT, MD 21215				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		1-18-84	Oak Lawn Cemetery	Eastwood, Balto. Co., Md.		
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		
Charles S. Zeiler & Son Inc. 6224 Eastern Ave.				1/18/84		

MEDICAL CERTIFICATION

January 10, 1911

White

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 / 0 5

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Hoyt Earl Asher			2a. DATE OF DEATH MONTH DAY YEAR January 5, 1984		2b. HOUR 5:58 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 25 1932		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator		12b. KIND OF BUSINESS OR INDUSTRY Nelson Co.
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Edgemere	
14. FATHER'S NAME FIRST MIDDLE LAST Rev. Thomas H. Asher			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice Estelle Armstrong		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-32-0718		17. INFORMANT ADDRESS Marguerite Coleman 1201 E. Patrick St. Frederick, MD 21701	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

1579 IMMEDIATE CAUSE (a) respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) anasarca
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 hours

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c):

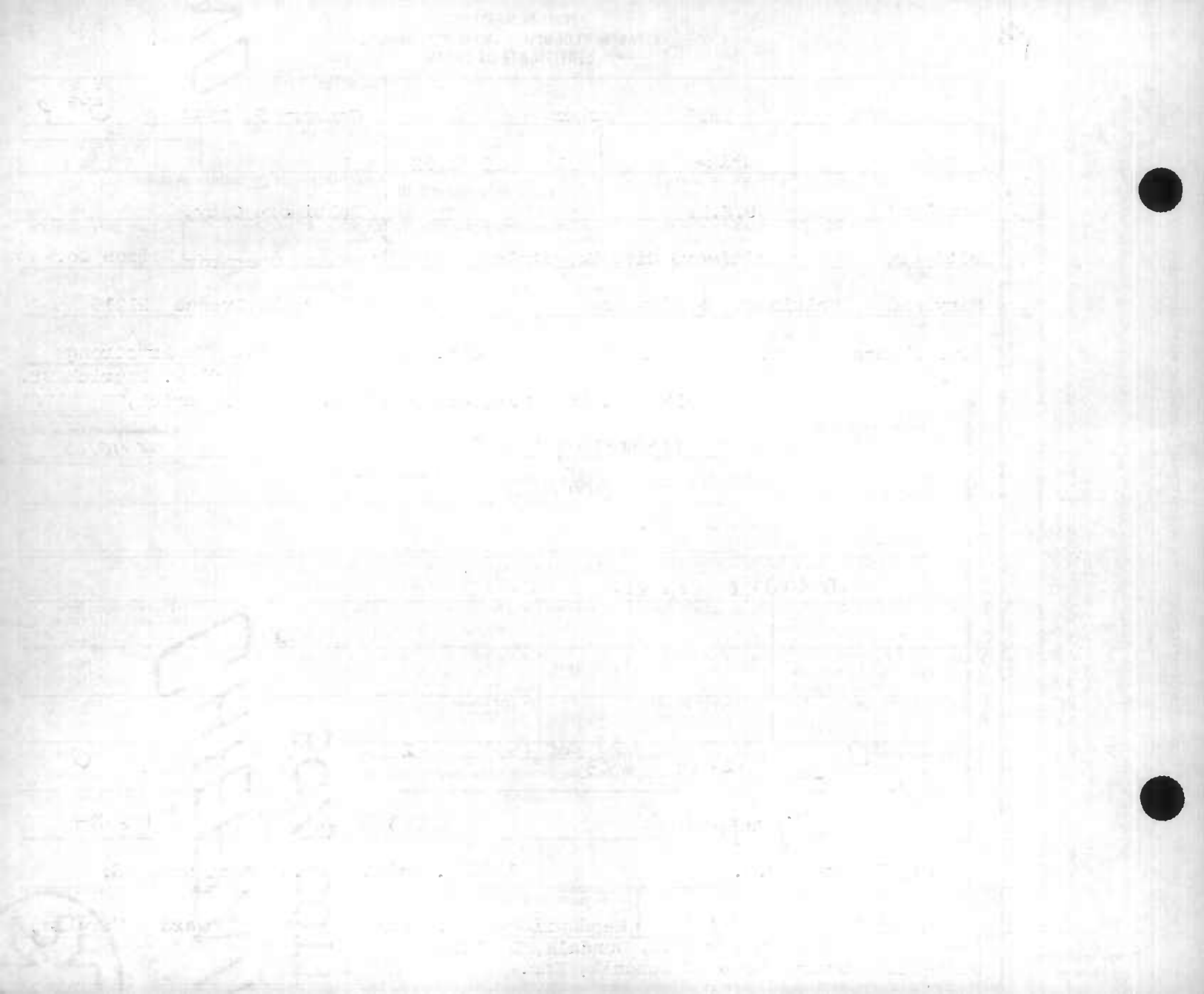
pancreatic cancer

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 15</u> , 19 <u>82</u> , to <u>present</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>12-19</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Jay Lippman MD</u>		DEGREE		22c. DATE SIGNED 1-6-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jay Lippman, M.D.		22e. ADDRESS 1005 N. Point Blvd., Baltimore, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/9/84	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park	23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Howard Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue, Dundalk, MD 21222		25a. DATE REC'D. BY REGISTRAR JAN 10 1984	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ² (WILLIE)			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 18, 1984			2b. HOUR 05:42PM			
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR APRIL 14 1914		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1729 NORTH WASHINGTON ST. 21213	
14. FATHER'S NAME FIRST MIDDLE LAST JONAH ASKEW				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA BURDEN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-05-3460		17. NAME AND ADDRESS MAMIE LEE HOGGARD 1729 N. WASHINGTON STREET 21213					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) possible myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) hypertension								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 75 min 50 min 20 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: chronic renal failure, chronic lung disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I (this hospital) attended the deceased from 1/18 19 84 to 1/18 19 84 , that (I) (we) last saw the deceased alive on 1/18 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dalla Botta				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/18/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dalla Botta				22e. ADDRESS Johns Hopkins Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 01/23/84		23c. NAME OF CEMETERY OR CREMATORY BURDEN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ORLANDER NORTH CAROLINA			
24a. NAME OF REGISTRAR W. JONES, JR.				24b. ADDRESS F.H. BALTO, Md.		25a. DATE REC'D. BY REGISTRAR JAN 20 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

HUNTER'S F.H./RHUE ST./AHOSKIE, N.C.

JAN 20 1984

[Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 42 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 4 0 0 / 0 7			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances M. ASTARITA				2a. DATE OF DEATH MONTH DAY YEAR January 1, 1984			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 6 1914		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Baltimore Rosedale				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1501 Brian Road - 21237	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Jamison		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maybelle Chase		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 215-22-8835		17. INFORMANT Luke L. Astarita		ADDRESS 1501 Brian Road Balto. MD 21237			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of colon and Pulmonary and x 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION December 27, 1983		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Right Malignant Pleural Effusion		20a. AUTOPSY? NO		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 26, 1983 , to JANUARY 1, 1984 , that (I) (we) lost saw the deceased alive on JANUARY 1, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. J. Helou, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-1-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. J. Helou M.D.				22e. ADDRESS Church Hospital 100 N. Broadway, Baltimore, 21231			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/4/84		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary		23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk, Baltimore, MD	
24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck, Inc. 7922 Wise Avenue, Dundalk, MD 21222				25a. DATE REC'D. BY REGISTRAR JAN 3 1984		25b. REGISTRAR'S SIGNATURE <i>John J. Canish</i>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 7 0 8

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ERNEST ATKINS		2a. DATE OF DEATH MONTH DAY YEAR JANUARY 8, 1984		2b. HOUR 11:05A_M	
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 3 16 1889		6. AGE (IN YEARS LAST BIRTHDAY) 99	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KINSTON, Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.	
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOME HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DAVIDSON CHEM.		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY BALTO.		13c. STREET ADDRESS 1618 ASHLAND AVE. 21205	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN ATKINS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MIDA FIELDS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS DOROTHY SPICER 2015 W. 3RD ST.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CEREBROVASCULAR ACCIDENT****4360**

DUE TO, OR AS A CONSEQUENCE OF

(b) **MX ATHEROSCLEROSIS**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

HYPOTHERMIA

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>JANUARY 3, 1984</u> to <u>JANUARY 8, 1984</u> , that (I) <u>we</u> last saw the deceased alive on <u>JANUARY 8, 1984</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> <u>did not</u> view the body after death.							
22b. SIGNATURE Janice Rutkowski, MD DEGREE MD						22c. DATE SIGNED JAN 8, 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JANICE RUTKOWSKI, MD.				22e. ADDRESS CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/11/84		23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE MAGOTHY, Md.	
24. FUNERAL DIRECTOR LEROY O. DYETT 4600 LIBERTY HGTS. AVE.				25a. DATE REC'D. BY REGISTRAR JAN 10 1984		25b. REGISTRAR'S SIGNATURE Amel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84 00 / 09

1- FOR
STATE
REGISTRAR

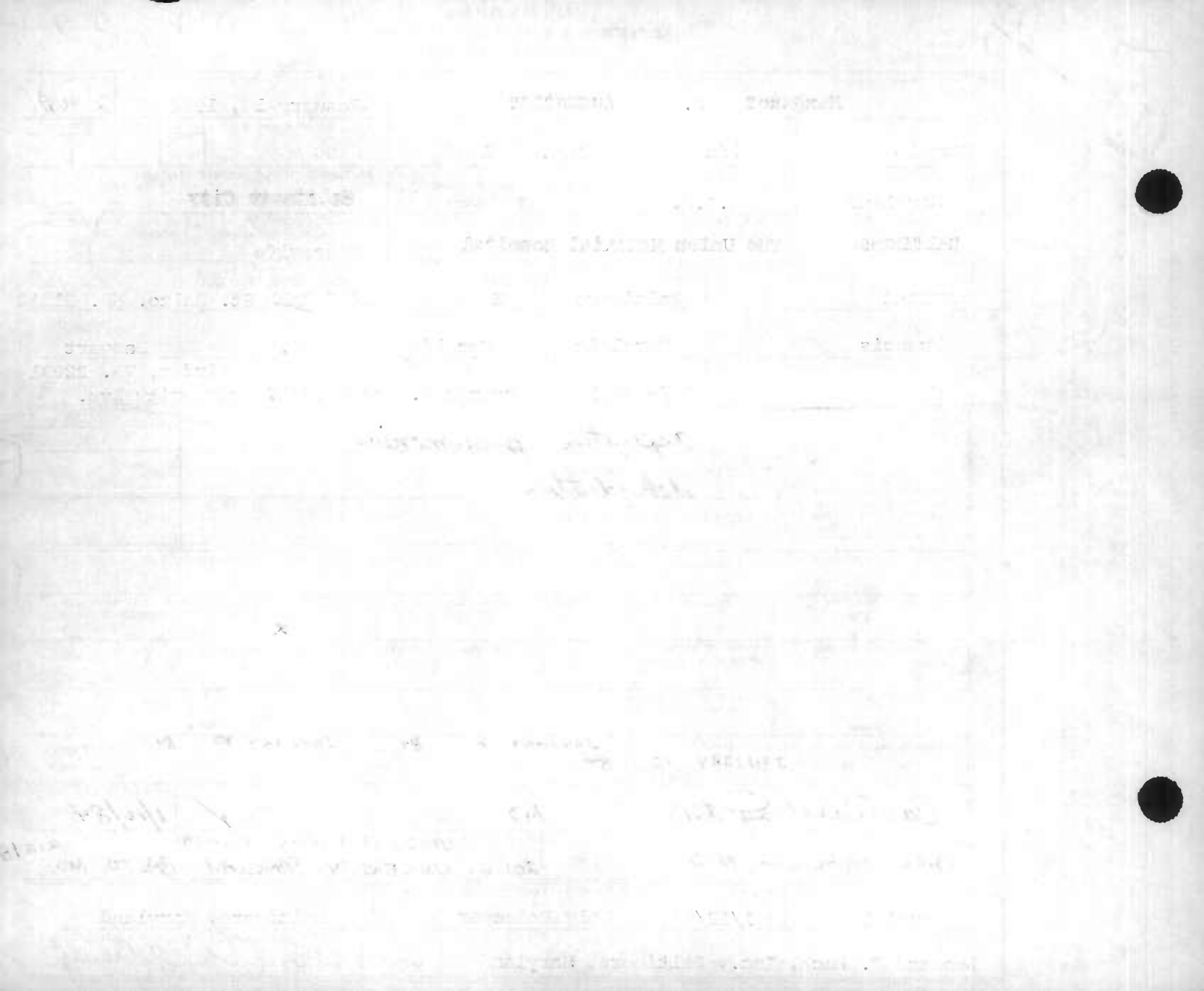
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret C. Augustine			2a. DATE OF DEATH MONTH DAY YEAR January 10, 1984		2b. HOUR 2:40 A.M.
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 5, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		
13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Francis Herrlein			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cecelia Bangert		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217-05-9154		17. INFORMANT ADDRESS Margaret H. Crosby, 3517 Prosperity Ave. Fairfax, VA. 22031	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aspiration pneumonia 2765 DUE TO, OR AS A CONSEQUENCE OF (b) dehydration DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 6, 1984 to JANUARY 10, 1984 , that (I) (we) lost saw the deceased alive on JANUARY 10, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Carl Sperling M.D.		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARL SPERLING, M.D.		22e. ADDRESS UNION MEMORIAL HOSPITAL 201 E. UNIVERSITY PARKWAY BALTO. MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/12/84	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc., Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 11 1984		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST John	MIDDLE Jack	LAST Austin	2a. DATE OF DEATH
						MONTH DAY YEAR
						1 16 84
3. SEX			4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7b. HOUR
MALE			White	Jan. 8 1939	45 YRS.	12:35A
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia			U.S.A.		Baltimore City MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore			Baltimore City Hospital		Watch Repairman self-employed	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Md. STATE			Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1213 Gusryan St. 21224	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Otis Austin			FIRST MIDDLE LAST Irene Brown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
no			216-36-9045A	Dora Austin (wife) same address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxic Brain Damage, Hypoxia, Hypotension</u> <u>4275</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEIZURE</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>25 hours</u> <u>25 hours</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hemophilia</u>						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>14 January 1984</u> , to <u>16 January 1984</u> , that (I) (we) lost saw the deceased alive on <u>16 January 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE					22c. DATE SIGNED	
<u>Raymond W. Wilson, MD</u>					1-16-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS	
Raymond W. Wilson, MD					Baltimore City Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	
Burial			1/19/84	Oak Lawn	Baltimore COUNTY Md. STATE	
24. FUNERAL DIRECTOR				25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Schiffunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213				JAN 17 1984		<u>John J. Gair</u>

BP

UNITED STATES
DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY



PAID BY ADDRESSEE

NOV 20 1904

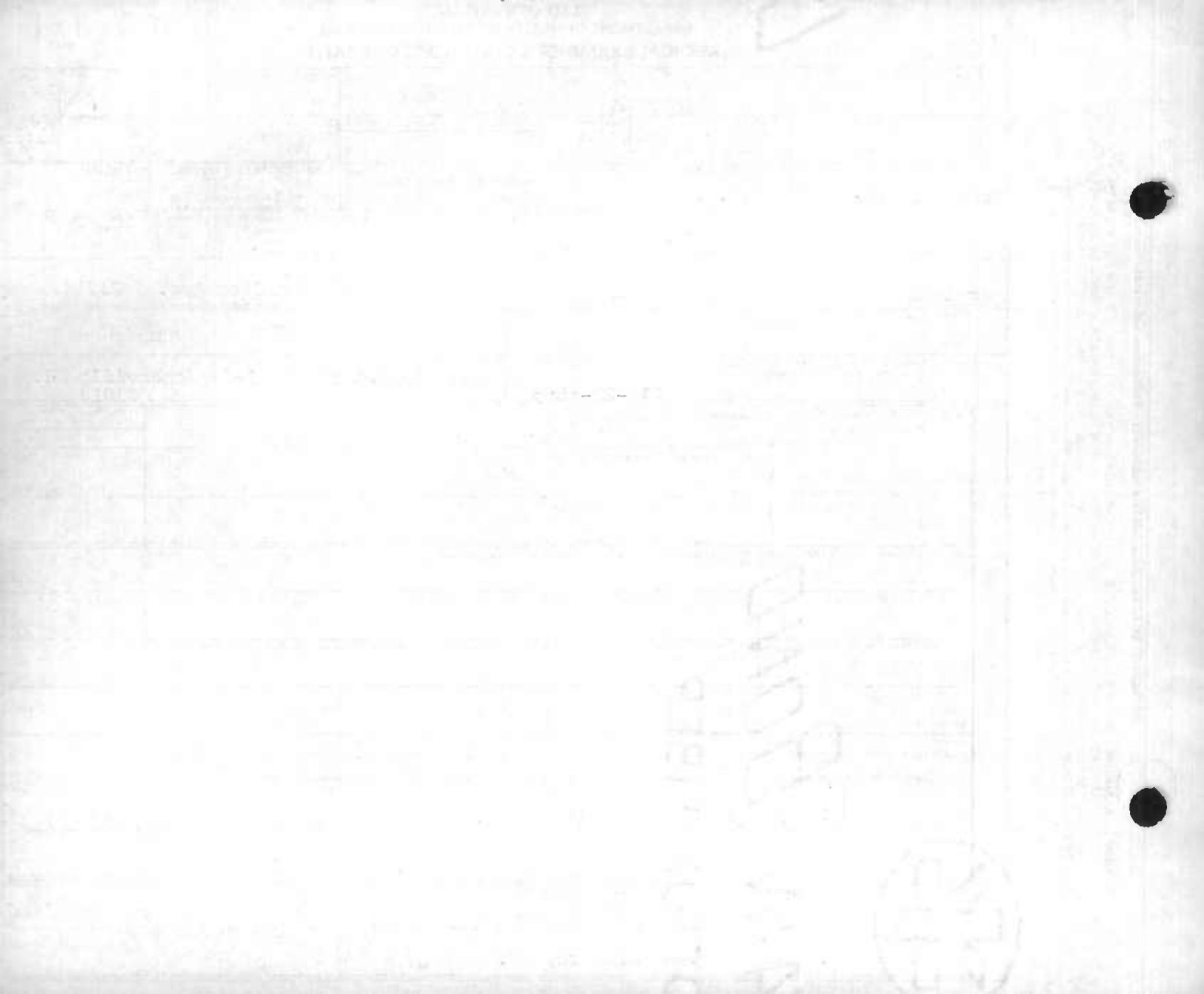
1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Maxine			MIDDLE LOVELLA			LAST Auvil			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 1-27 1984			2b. HOUR M 11:35 a.m.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 1, 1923		6. AGE (IN YEARS) (LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-27 1984			2d. HOUR M a.m.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2810 Hamilton Avenue						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2810 Hamilton Ave. 21214							
14. FATHER'S NAME FIRST MIDDLE LAST Ray O. Haller						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilma Murphy											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-22-6883		17. INFORMANT ADDRESS Mrs. Sharlet Clark 1619 Somerville Rd. 21014											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?													
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) Assistant				M.D. MEDICAL EXAMINER				DATE SIGNED 1-27-84					
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-30-84		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens				23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Maryland							
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.						ADDRESS Baltimore, Md.				25a. DATE REC'D. BY REGISTRAR JAN 30 1984		25b. REGISTRAR'S SIGNATURE John J. Lohr					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE MEDICAL EXAMINER BY TELEPHONE. INSTRUCTIONS FOR FILING OF THIS CERTIFICATE ARE SET FORTH ON THE REVERSE SIDE OF THIS FORM. **QUESTIONS:** IF YOU HAVE ANY QUESTIONS CONCERNING THIS FORM, PLEASE CALL THE HEALTH DEPARTMENT AT (708) 961-1234.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
20M 4/B2

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

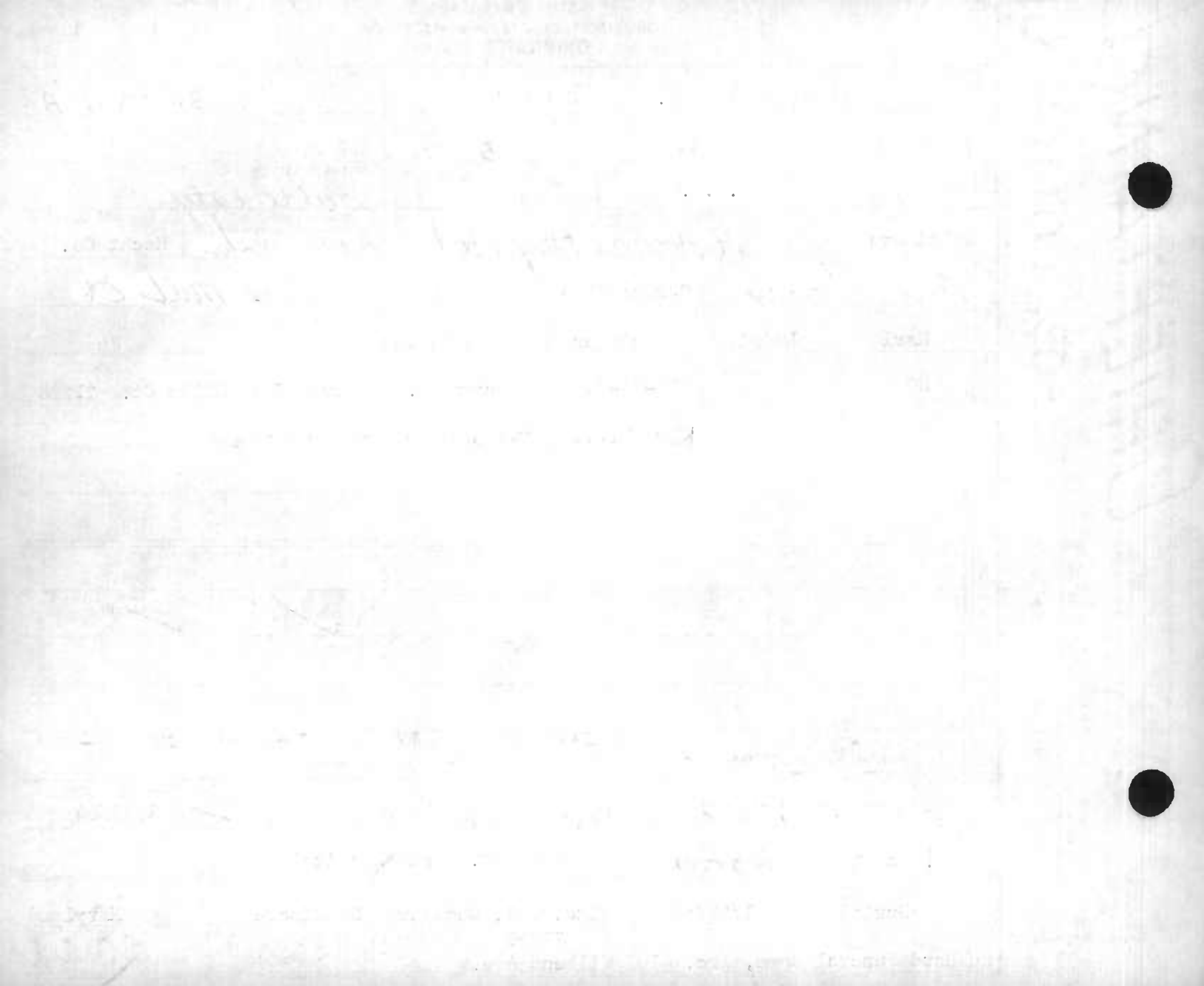
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8400713			
1. FOR STATE REGISTRAR				7a. DATE OF DEATH MONTH DAY YEAR 1 21 84			
2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILLIAN E. BAADER				7b. HOUR 1 A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 5 02		6. AGE (IN YEARS LAST BIRTHDAY) 81	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson		12b. KIND OF BUSINESS OR INDUSTRY Hecht Co.	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Karl Ludwig Metzger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Fug		13e. STREET ADDRESS 4 York Mills Court 21228			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-36-2539		17. INFORMANT ADDRESS Norman H. Baader 4 York Mills Ct. 21228			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured thoracic aortic aneurysm 4411							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from JAN 17 19 84, to JAN 21 19 84, that (we) lost saw the deceased alive on JAN 21 19 84, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bert F. Morton, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/21/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bert F. Morton				22e. ADDRESS St. Agnes Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/25/84		23c. NAME OF CEMETERY OR CREMATORY Balto. Ntl. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.				25a. DATE REC'D. BY REGISTRAR 21229 JAN 23 1984		25b. REGISTRAR'S SIGNATURE	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be kept with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8400714

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARY A. BACK			2a. DATE OF DEATH MONTH 1 DAY 7 YEAR 84			2b. HOUR 8:32A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 4 DAY 13 YEAR 98		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. CITY OR TOWN Baltimore 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13d. STREET ADDRESS 1624 Manor Rd. 21222			
14. FATHER'S NAME FIRST Vaclav MIDDLE Barborka LAST Marie				15. MOTHER'S MAIDEN NAME FIRST Marie MIDDLE Zoubek LAST Zoubek			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 214-74-0556		17. INFORMANT Sister Laurentilla Back Same as 13e	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Multiple CVA's Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 6 days				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from Jan 5 , 19 84 , to Jan 7 , 19 84 , that (1) (we) lost saw the deceased alive on Jan 7 , 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.					
22b. SIGNATURE Robert E. Fisher				22c. DATE SIGNED 1/7/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert E. Fisher				22e. ADDRESS 4940 Eastern Ave. Balt. MD 21204	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/10/84		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.		ADDRESS 7922 Wise Ave. 21222		25a. DATE REC'D. BY REGISTRAR JAN 10 1984	
				25b. REGISTRAR'S SIGNATURE John J. Lawler	

BP

NOV 11 1953

13

#2a, 17, per F.H. 2/15/84 km
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) KATHRYN W BAERHOLD			2a. DATE OF DEATH MONTH 9 DAY 9 YEAR 1984			2b. HOUR 12:03a M					
3. SEX Female		4. RACE Caucasin		5. DATE OF BIRTH MONTH 1 DAY 25 YEAR 1917		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Univ. Hosp.			
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4314 Holbrook Road 21133			
14. FATHER'S NAME FIRST Charles MIDDLE D. LAST Wilson				15. MOTHER'S MAIDEN NAME FIRST Lillian MIDDLE M. LAST Nelson				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)			
16b. SOCIAL SECURITY NO. 213-38-9805				17. INFORMANT A. Barbara W. Tanner				ADDRESS Baltimore 21207 1845 Sutton Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension, Bradycardia, Asystole 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction, Pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (c) CHF, Renal insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 12-25- 19 83 to 1-9- 19 84 , that (h) (we) last saw the deceased alive on 1-9- 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Philip H. San						DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-9-1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 1-9-84		23c. NAME OF CEMETERY OR CREMATORY Security Process			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md		25b. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 11 1984	
24. FUNERAL DIRECTOR MacNabb Funeral Home Catonsville, Md											

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10:00

X

10:00

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JAMES EARL BAILEY			2a. DATE OF DEATH MONTH DAY YEAR 1 10 84			2b. HOUR 4:54P M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 26 05		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, BALTIMORE, MD. 21218				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 703 McCabe Avenue 21212	
14. FATHER'S NAME FIRST MIDDLE LAST James Bailey			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Gail						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 214-01-2155		17. INFORMANT ADDRESS Lillian M. King 1100 Pennsylvania Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4275 Cardiac arrest (multiple for 24 hrs. preceding death) DUE TO, OR AS A CONSEQUENCE OF (b) Biventricular CHF DUE TO, OR AS A CONSEQUENCE OF (c) Atrial fibrillation - hx of atrial fib. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 29 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/4 , 19 84 , to 1/10/ , 19 84 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on above 1/10 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above 1/10 (we) (did) (not) view the body after death.									
22b. SIGNATURE H. Lamm MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1-11-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Lamm MD				22e. ADDRESS 3900 LOCH RAVEN BLVD, BALTO. MD. 21218					
23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL		23b. DATE 1/17/84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA		23d. LOCATION CITY OR TOWN COUNTY STATE Owing Mills, Md.			
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc, 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR JAN 12 1984		25b. REGISTRAR'S SIGNATURE John J. Lamm			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARTHA BAILEY			2a. DATE OF DEATH MONTH 01 DAY 04 YEAR 84			2b. HOUR 11:10 P.M.		
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH 12 DAY 02 YEAR 1917		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Car.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.		
10. CITY OR TOWN OF DEATH Balto City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital of Balto				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD COUNTY Balto CITY OR TOWN Balto			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 1323 W. Saratoga St. 21223			
14. FATHER'S NAME FIRST Louis MIDDLE LAST Wheeler			15. MOTHER'S MAIDEN NAME FIRST Nora MIDDLE LAST Wheeler					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 215-12-8140		17. INFORMANT ADDRESS Charles Bailey 1323 W. Saratoga St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest. 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) metastatic lung ca DUE TO, OR AS A CONSEQUENCE OF (c) adenocarcinoma of colon 5/81								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/2/84 to 1/4/84 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 1/4/84 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.								
22b. SIGNATURE M. J. Gorer MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/4/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MURNA I. GORER			22e. ADDRESS 5861-D Western Run Dr. Balto, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/9/84		23c. NAME OF CEMETERY OR CREMATORY Maryland National		23d. LOCATION CITY OR TOWN Laurel COUNTY Md. STATE	
24. FUNERAL DIRECTOR NAME Leroy O. Dyett & Son F.H., Inc. ADDRESS 4600 Liberty			25a. DATE REC'D. BY REGISTRAR 1/10/84			25b. REGISTRAR'S SIGNATURE Chas. J. Connel		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

4791A

1991

Levy O Dettis 2nd 111 The Woodbury Road
Rumney 119184 Maryland District

RELEASED AS NON MED BY DR DIXON OF THE

MEDICAL EXAMINER'S OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, without any injury, or other traumatic event, the medical examiner may be contacted.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8. 4 000718

1. DECEASED NAME (TYPE OR PRINT) SAM Fred BAILEY			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 19, 1984			2b. HOUR 10:43AM	
3. SEX Male		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR June 2, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman	
12b. KIND OF BUSINESS OR INDUSTRY Steel Co.							
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 2634 E. Biddle St. 21213							
14. FATHER'S NAME FIRST MIDDLE LAST SAM Bailey Cora		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hardy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-07-1085		17. INFORMANT ADDRESS Mrs. Elta Bailey 2634 E. Biddle St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) possible myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/19 , 19 84 , to 1/19 , 19 84 , that (I) (we) last saw the deceased alive on 1/19 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Maria T. Aristiguet		DEGREE MD				22c. DATE SIGNED 1/19/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARIA T. Aristiguet		22e. ADDRESS Q1H					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Branch's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Victoria Va.	
24. FUNERAL DIRECTOR NAME Randolph J. Collick		ADDRESS 2431 E. Oliver St.		25a. DATE REC'D. BY REGISTRAR JAN 20 1984		25b. REGISTRAR'S SIGNATURE John J. Connel	

1954



RECEIVED

20%

RECEIVED
JAN 21 1954
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) STANLEY WILLIAM BAK			2a. DATE OF DEATH MONTH 1 DAY 28 YEAR 84			2b. HOUR 4:00 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 7 DAY 19 YEAR 02		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shipping Supv.		12b. KIND OF BUSINESS OR INDUSTRY Paper Supply	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Francis MIDDLE Bak LAST Bak		15. MOTHER'S MAIDEN NAME FIRST Rosalie MIDDLE Banacki LAST Banacki					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-07-7581		17. INFORMANT ADDRESS Mrs. Helene E. Bak, 3209 E. Pratt Street Baltimore, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crytogenic Cirrhosis 1850 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Prostate DUE TO, OR AS A CONSEQUENCE OF (c) Hepatic encephalopathy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/28 19 84 , to 1/28 19 84 , that (I) (we) last saw the deceased alive on 1/28 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard L. Linthicum M.D.				DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD L. LINTHICUM				22e. ADDRESS MERCY HOSPITAL			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-1-84		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.	
24. FUNERAL DIRECTOR Nicholas T. Matthews, 3021 Eastern Avenue Baltimore, Md.				25a. DATE REC'D. BY REGISTRAR FEB 3 - 1984		25b. REGISTRAR'S SIGNATURE John J. Conner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 4 0 0 / 2 0	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Arthur L. Baldwin Sr.			2a. DATE OF DEATH MONTH DAY YEAR Jan. 13, 1984		2b. HOUR M
3. SEX Male.	4. RACE Cau.	5. DATE OF BIRTH MONTH DAY YEAR 11-7-01		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3404 Chestnut Ave.		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mutual Clerk (Ret.)		
13b. COUNTY Balto.			12c. KIND OF BUSINESS OR INDUSTRY Race Track.		
14. FATHER'S NAME FIRST MIDDLE LAST ? ? ?			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? ? ?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 218-10-6916		17. INFORMANT ADDRESS Maurice A. Baldwin Sr. 9126 Old Harford Rd. 34	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 ACUTE MYOCARDIAL INFARCTION IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 71 , 19 84 , to JAN 13 , 19 84 , that (I) (we) last saw the deceased alive on JAN 3 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Marcio M. Menendez		DEGREE M.D.		22c. DATE SIGNED 1/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Marcio M. Menendez M.D.		22e. ADDRESS 5820 York Road. Balto, Md. 21212			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial.		23b. DATE Jan. 16, 1984		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge.	
23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Paul E. Chenoweth 3615-19 Chestnut Ave.		25a. DATE REC'D. BY REGISTRAR JAN 17 1984		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>	

BP

Jan. 13, 1951

Arthur A. Schmitt Jr.

88

11-7-51

San

Ala.

City

1951

No.

Normal Black and White Photo

1951 Schmitt Ave.

Ala.

1951 Schmitt Ave.

Ala.

No.

1951 Schmitt Ave. 1951 Schmitt Ave. 1951 Schmitt Ave.

No.

1951 Schmitt Ave. 1951 Schmitt Ave. 1951 Schmitt Ave.

1951 Schmitt Ave. 1951 Schmitt Ave. 1951 Schmitt Ave.

1951 Schmitt Ave.

1951 Schmitt Ave.

1951 Schmitt Ave.

1951 Schmitt Ave. 1951 Schmitt Ave. 1951 Schmitt Ave.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES (BALARK) BALLARK			2a. DATE OF DEATH MONTH 1 DAY 10 YEAR 1984		2b. HOUR 1:26 M
3. SEX M	4. RACE BLACK	5. DATE OF BIRTH MONTH 8 DAY 15 YEAR 20		6. AGE (IN YEARS LAST BIRTHDAY) 63	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (COUNTRY) Jacksonville Fla.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.	
10. CITY OR TOWN OF DEATH Balto	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Coast Guard		12b. KIND OF BUSINESS OR INDUSTRY BOAT.
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Eugene MIDDLE Balark LAST		15. MOTHER'S MAIDEN NAME FIRST MAMIE MIDDLE Griffin LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 241-14-3096		17. INFORMANT ADDRESS Mrs. ESTELLE Balark - 3237 NORMOUNT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory arrest 1629 DUE TO, OR AS A CONSEQUENCE OF (b) obstructive lesion / pleural effusion DUE TO, OR AS A CONSEQUENCE OF (c) non-small cell lung ca					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: pneumonia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/30 19 83 , to 1/10 19 84 , that (I) (we) lost saw the deceased alive on 1/10 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) not view the body after death.					
22b. SIGNATURE Julie L. Seely		DEGREE MD		22c. DATE SIGNED 1/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JULIE L. SEELY		22e. ADDRESS Sinai Hospital			
23a. BURIAL, CREMATION, REMOVAL (CLASSIFY) BURIAL		23b. DATE 1-15-84	23c. NAME OF CEMETERY OR CREMATORY Henderson Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE CARTHAGE, N.C.
24. FUNERAL DIRECTOR NAME JAS. A. MORTON & SONS		ADDRESS 1701 LAURENS		25a. DATE REC'D. BY REGISTRAR JAN 13 1984	
		25b. REGISTRAR'S SIGNATURE John J. Connel			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

BP

60% COTTON

100% COTTON



MADE IN U.S.A.
100% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
ARNO BAMBERGER				JANUARY 25, 1984				2:08 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
MALE		CAUCASIAN		02 18 1900		83 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
GERMANY		U.S.A.				BALTIMORE CITY, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		REISTERSTOWN ROAD PLAZA				SALESMAN		FURNITURE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
13a. STATE		13b. COUNTY		YES XX NO <input type="checkbox"/>		4116 FORDLEIGH ROAD (21215)			
MARYLAND		BALTIMORE							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST		MIDDLE		LAST		FIRST		MIDDLE	
JOSEPH				BAMBERGER		JOSEPHINE		KROUSE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO				217-20-3815		KATHE BAMBERGER 4116 FORDLEIGH ROAD (21215)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Acute MI</u>								<u>min</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUPLICATE OF CAUSE OF DEATH (b) <u>ASCD</u>									
DUPLICATE OF CAUSE OF DEATH (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>? Tuberculosis</u>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				HOUR A.M. MONTH DAY YEAR					
				P.M. 19					
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/19/83</u> to <u>1/25/84</u> , that (I) (we) saw the deceased alive on <u>8/19/83</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did <u>(not)</u> view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
<u>SID Macinew</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				<u>1/26/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
<u>S.H. MACINEW</u>				<u>3625 O'H COMPTON</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL				JAN. 27, 1984		CHEVRA AHAVAS CHESD		RANDALLSTOWN BALTO. MARYLAND	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
BALTIMORE, MARYLAND 21215				FEB 1 1984				<u>[Signature]</u>	
SOL LEVINSON & BROS. 6010 REISTERSTOWN ROAD									

BP _____

10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MICHAEL L. (BANDOR) Bandurski			2a. DATE OF DEATH MONTH DAY YEAR 1/30/84		2b. HOUR 5:39 PM
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Unknown 1902	6. AGE (IN YEARS LAST BIRTHDAY) 81	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK, FOR MOST OF WORKING LIFE) Not known	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Hopkins Ct. Apts. #605 21230
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Bandurski		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Victoria Tomaszewicz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. ←		17. INFORMANT ADDRESS James Bandurski 320 Collington Ave.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5698 IMMEDIATE CAUSE (a) CARDIAC ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) PERFORATED TRANSVERSE COLON		6 hrs.
DUE TO, OR AS A CONSEQUENCE OF (c) LIVER CIRRHOSIS.		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a
EMPHYSEMA.

19a. DATE OF OPERATION 1/30/84	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATE TRANSVERSE COLON	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/30/84 to 1/30/84 , that (I) (we) lost saw the deceased alive on 1/30/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE S. Fereshetian		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 1/30/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SITATHE FERESHETIAN		22e. ADDRESS UNION MEMORIAL HOSPITAL	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 2-2-84	23c. NAME OF CEMETERY OR CREMATORY WEST VIEW	23d. LOCATION CITY OR TOWN COUNTY STATE BALTO BALTO MD
24. FUNERAL DIRECTOR NAME JOHN M. WEBER & SONS INC.		ADDRESS 401 S. CHESTER ST.	25a. DATE REC'D. BY REGISTRAR FEB 3 1984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 / 2 4

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MAURICE JOHN BANFORD			2a. DATE OF DEATH MONTH DAY YEAR January 10, 1984		2b. HOUR 7:30 M		
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 21, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S. BALTIMORE GEN HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY School Sys.	
13a. STATE Iowa		13b. COUNTY Story		13c. CITY OR TOWN Gilbert		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES M. BANFORD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH O. MILLER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 484.16.4022	
17. INFORMANT (son in law)		ADDRESS 7632 Third Ave.		18. Mr. Gerald L. Clouser		Glen Burnie, MD	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:

0389 IMMEDIATE CAUSE (a) **cardiopulmonary arrest**

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Sepsis**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

Refractory Anemia, Renal failure

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/28 , 19 83 , to 1/10 , 19 84 , that (I) (we) last saw the deceased alive on 1/10 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Peter H Cooke				DEGREE MD		22c. DATE SIGNED 1/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER H COOKE				22e. ADDRESS 3001 S. HANOVER BALTIMORE			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 14, 84		23c. NAME OF CEMETERY OR CREMATORY Gilbert Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Gilbert Story, Iowa	
24. FUNERAL DIRECTOR NAME A. B. Vinton ADDRESS Singleton Funeral Home Glen Burnie, Md.				25a. DATE REC'D. BY REGISTRAR JAN 13 1984		25b. REGISTRAR'S SIGNATURE John J. Casel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

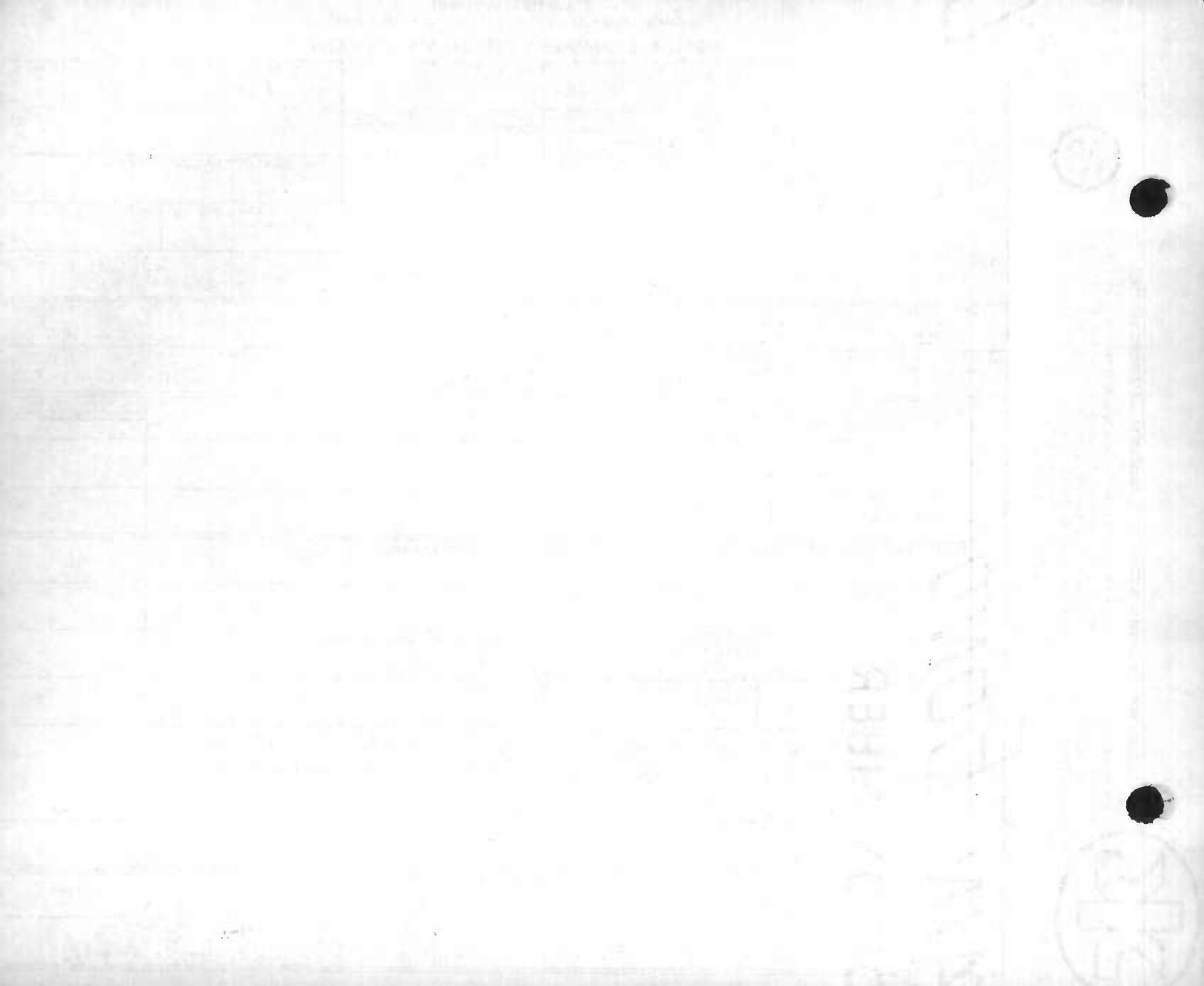
RECEIVED
JAN 10 1964

CHIEF XXIV
100% COLLECT

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Linkford M. Banks										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1/5/84 19	
3. SEX male	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 3 17 13	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 1/5/84 19	7d. HOUR 956	7e. MIN. A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1333 Glenwood Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1333 Glenwood Avenue 21239			
14. FATHER'S NAME FIRST MIDDLE LAST George W. Banks				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Fisher							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 217-07-6784		17. INFORMANT ADDRESS Marie A. Banks 1333 Glenwood Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9660 IMMEDIATE CAUSE (a) Incised wounds of Neck and Chest DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9:45xx 1/5/84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject stabbed							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1333 Glenwood Ave., Balto. City, Md							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		ASSISTANT MEDICAL EXAMINER						DATE SIGNED 1/5/84			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/10/84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA				23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Md			
24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Ave				25a. DATE REC'D. BY REGISTRAR JAN 9 1984		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>					

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8400726

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JEANNETTE MABEL BARATH			2a. DATE OF DEATH MONTH DAY YEAR 01 11 84		2b. HOUR 5:00P
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR June 3 1927	6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 56
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12. USUAL OCCUPATION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Assistant	12b. KIND OF BUSINESS OR INDUSTRY C&P Telephone	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY Md. A.A.			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 21122 7633 Colonial Beach Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST George William Hinks			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jeannette Mabel Smith		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No Na		16b. SOCIAL SECURITY NO. 217-24-9533	17. INFORMANT ADDRESS Mr. Ernest J. Barath Same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 0389 CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SEPSIS AND GI BLEEDING DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 12 hrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: METASTATIC ADENOCARCINOMA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I (this hospital) attended the deceased from 1/11 84 to 1/11 84 , that (I (we) last saw the deceased alive on 1/11 84 , and that in (my (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) did (did not) view the body after death.					
22a. SIGNATURE Boylan		DEGREE		22c. DATE SIGNED 1/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kevin BOYLAN		22e. ADDRESS 601 N. Wolfe St.		22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 16 Jan 84	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem.Pk. ElkrIDGE Howard Md.		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Singleton Funeral Home Glen Burnie Md.		ADDRESS		25a. DATE REGD. BY REGISTRAR JAN 13 1984	
				25b. REGISTRAR'S SIGNATURE John J. Carver	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

Washington Bureau, New York, New York

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84000727

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPHINE I. BARCLAY			2a. DATE OF DEATH MONTH DAY YEAR 1/14/84			2b. HOUR 2:50 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 3 03		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 21218 UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3838 Roland Ave. 21211	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Woltjen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Rudy						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 220-32-3771		17. INFORMANT ADDRESS Mr. Charles Woltjen 11010 Keswick Road Philadelphia, Pa. 19154				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Tracheal edema**
4787
DUE TO, OR AS A CONSEQUENCE OF
(b) **CHF**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) **CORD**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

CHF, CORD

19a. DATE OF OPERATION 1/12/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Laryngeal abscess		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/13 , 19 84 , to 1/14 , 19 84 , that (I) (we) lost saw the deceased alive on 1/14 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Mark N. Strong MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/14/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK N. STRONG				22e. ADDRESS Union Memorial Hospital			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1/18/84		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
--	--	-----------------------------	--	--	--	---	--

24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr.		ADDRESS 3818 Roland Ave. 21211		25a. DATE REC'D. BY REGISTRAR JAN 23 1984		25b. REGISTRAR'S SIGNATURE John J. Grier	
---	--	--	--	---	--	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

BP

1

DATE	DESCRIPTION	AMOUNT	BALANCE
1911			
1912			
1913			
1914			
1915			
1916			
1917			
1918			
1919			
1920			
1921			
1922			
1923			
1924			
1925			
1926			
1927			
1928			
1929			
1930			
1931			
1932			
1933			
1934			
1935			
1936			
1937			
1938			
1939			
1940			
1941			
1942			
1943			
1944			
1945			
1946			
1947			
1948			
1949			
1950			
1951			
1952			
1953			
1954			
1955			
1956			
1957			
1958			
1959			
1960			
1961			
1962			
1963			
1964			
1965			
1966			
1967			
1968			
1969			
1970			
1971			
1972			
1973			
1974			
1975			
1976			
1977			
1978			
1979			
1980			
1981			
1982			
1983			
1984			
1985			
1986			
1987			
1988			
1989			
1990			
1991			
1992			
1993			
1994			
1995			
1996			
1997			
1998			
1999			
2000			
2001			
2002			
2003			
2004			
2005			
2006			
2007			
2008			
2009			
2010			
2011			
2012			
2013			
2014			
2015			
2016			
2017			
2018			
2019			
2020			
2021			
2022			
2023			
2024			
2025			
2026			
2027			
2028			
2029			
2030			
2031			
2032			
2033			
2034			
2035			
2036			
2037			
2038			
2039			
2040			
2041			
2042			
2043			
2044			
2045			
2046			
2047			
2048			
2049			
2050			
2051			
2052			
2053			
2054			
2055			
2056			
2057			
2058			
2059			
2060			
2061			
2062			
2063			
2064			
2065			
2066			
2067			
2068			
2069			
2070			
2071			
2072			
2073			
2074			
2075			
2076			
2077			
2078			
2079			
2080			
2081			
2082			
2083			
2084			
2085			
2086			
2087			
2088			
2089			
2090			
2091			
2092			
2093			
2094			
2095			
2096			
2097			
2098			
2099			
2100			

20% COTTON
CIVILIAN
MILITARY



Handwritten text at the bottom of the page, possibly a signature or date.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 / 2 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William Lee Barenburg			2a. DATE OF DEATH MONTH DAY YEAR 1 3 84			2b. HOUR 2:50 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 26 49		6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dentist	
12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		13a. STATE MARYLAND		13b. CITY OR TOWN Baltimore		13c. STREET ADDRESS 6006 Ivydele Terr. 21209	
14. FATHER'S NAME FIRST MIDDLE LAST EUGENE RUDOLPH BARENBURG		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JANET BERTHA LINGG		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 217.50.3875	
17. INFORMANT ADDRESS ROSEMARY BARENBURG SAME AS 13c.							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebrovascular accident

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) Myocardial infarction (presumed)

DUE TO, OR AS A CONSEQUENCE OF

(c) Adenocarcinoma of lung

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Steven L. Ballas</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/3/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN L. BALLAS		22e. ADDRESS SINAI HOSPITAL					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 1/4/1984		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222				25a. DATE REC'D. BY REGISTRAR JAN 4 1984		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten text on lined paper, mostly illegible due to fading. The text appears to be organized into several paragraphs or sections, with some lines starting with capital letters. The handwriting is cursive and somewhat slanted.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8400729

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anna B. Barker Barker			2a. DATE OF DEATH MONTH DAY YEAR 1-31-84		2b. HOUR 5:54AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 11-17-33		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS	12b. KIND OF BUSINESS OR INDUSTRY CLOTHES SEWING	
13a. STATE MD	13b. COUNTY A.A.	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Glen Burnie Md. 21061 1270 Warwickshire Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Jesse Redin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Landis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-30-6055		17. INFORMANT ANN SAMPLES ADDRESS 7385 AFTON COURT HANOVER MD. 21076	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

1890

IMMEDIATE CAUSE (a) **Respiratory Arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) **Pleural Effusion**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Metastatic Hyper-nephroma**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-25 , 19 84 , to 1-31 , 19 84 , that (II) (we) lost saw the deceased alive on 1-31 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Charles G. Richards, MD	DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 1-31-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Berkman		22e. ADDRESS 3001 S. Hanover	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 2/3/84	23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Pr.	23d. LOCATION CITY OR TOWN COUNTY STATE CATONSVILLE BALTO Co. MD.
24. FUNERAL DIRECTOR NAME GEORGE J. GONCE	4001 PITCHIE HWY. BALTIMORE MD. 21225		25a. DATE REC'D. BY REGISTRAR FEB 3 1984
		25b. REGISTRAR'S SIGNATURE <i>John J. [Signature]</i>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100
A

20% COIL
CHIEF



some time before in 1902
the first time

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

00730

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM NORMAN BARNES			2a. DATE OF DEATH MONTH DAY YEAR January 4, 1984			2b. HOUR 2:30P M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 6, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTO MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Drive		12b. KIND OF BUSINESS OR INDUSTRY Trucking			
13a. STATE Md			13b. COUNTY CARROLL		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3634 Sykesville Rd.		
14. FATHER'S NAME FIRST MIDDLE LAST Walter Gilbert Barnes				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Barnes							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II		17. INFORMANT EARL BARNES		ADDRESS Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 2390 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION OF GASTRIC CONTENT IN BOTH LUNGS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) WIDESPREAD HEPATIC TUMOR GROWTH										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 16, 1984, to Jan. 4, 1984, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Jan. 4, 1984, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (If we) (did) (did not) view the body after death.											
22b. SIGNATURE A. Foony MP				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-5-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Foony				22e. ADDRESS 3900 Loch Raven Blvd. Balto Md 21218							
23a. BURIAL, CREMATION, REMOVAL (1) Burial			23b. DATE 1-7-84		23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Finkoping Carroll Md.			
24. FUNERAL DIRECTOR HARRY W. HIGHT				ADDRESS Sykesville, Md.		25a. DATE REC'D. BY REGISTRAR JAN 9 1984		25b. REGISTRAR'S SIGNATURE John J. Connel			

BP

DHMH - 16 50M 4/83

(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Number

Unit

U.S.A

111

60

July 2, 1953

Truck Drive Trucking

254 Sikesville Rd.

Barnes

Earl Barnes Sikesville, Md

The General Electric

Water Filter Barnes

Yes I want

1-8-54 General Electric

Water Filter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 7 3 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES Linwood BARRY JR.			2a. DATE OF DEATH MONTH DAY YEAR 1 JAN. 12, 1984			2b. HOUR 9:15 a.m.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 29, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 59		7. IF UNDER 1 YEAR MONTHS DAYS YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter		12b. KIND OF BUSINESS OR INDUSTRY A&P		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b. COUNTY Howard		13c. CITY OR TOWN Elkridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6625 Melrose Avenue (21227)	
14. FATHER'S NAME FIRST MIDDLE LAST James L. Barry, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matha Parrish							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II, Korea 215.12.45		17. INFORMANT Wife		ADDRESS Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) PROBABLE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE MYOCARDIAL RUPTURE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4/11 , 19 84 , to 1/12 , 19 84 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE William L. Yap			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 1/12/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM L. YAP M.D.			22e. ADDRESS ST. AGNES HOSPITAL BALTIMORE, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 16, 84		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem Pk			23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard MD		
24. FUNERAL DIRECTOR NAME H B Vinson ADDRESS Singleton Funeral Home, Glen Burnie, MD						25a. DATE REC'D. BY REGISTRAR JAN 13 1984		25b. REGISTRAR'S SIGNATURE Joan J. Canine		

BP

1917

1

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

BF

IMPORTANT: If Item 1 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

the medical institution must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY J. BARTHEL			2a. DATE OF DEATH MONTH DAY YEAR January 1, 1984		2b. HOUR 205 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 12, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long Green Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY St. of MD
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Baltimore	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Owen Blocher			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Hughlett Banning		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220 05 5732		17. INFORMANT ADDRESS Thomas P. Schmidt, Catonsville, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Attack</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Asc V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
22a. INJURY OCCURRED: WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 12/3 83		22c. LOCATION CITY OR TOWN COUNTY STATE 1/1 84	
23. I certify that (I) (this hospital) attended the deceased from <u>12/3 83</u> to <u>1/1 84</u> that (I) (we) last saw the deceased alive on <u>12/3 83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) did not view the body after death.					
24. SIGNATURE <u>Dr. William G. Helfrich</u>		DEGREE M.D.		25. DATE SIGNED 1/3/84	
26. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William G. Helfrich, M.D.		27. ADDRESS 5006 Roland Avenue, Balto., MD			
28a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		28b. DATE 1/4/84		28c. NAME OF CEMETERY OR CREMATORY Lorraine Park	
29a. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co.		29b. DATE REC'D. BY REGISTRAR JAN 3 1984		29c. REGISTRAR'S SIGNATURE <u>John E. Smith</u>	

↑ 2, 1, 2, 1, 2, 1

.L Y

U.S. DEPARTMENT OF JUSTICE

electronical

.CO .no- & nixreL .W yareH

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Gary E. Bartnik			2a. DATE OF DEATH MONTH 1 DAY 18 YEAR 84 M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 12 DAY 10 YEAR 50	6. AGE (IN YEARS LAST BIRTHDAY) 33 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4013 Walrad Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver-Monarch Prod.	
13a. STATE Md.		13b. CITY OR TOWN Balto.	13c. STREET ADDRESS Balto., Md. 104 S. Augusta Ave. #21229		
14. FATHER'S NAME FIRST Leo MIDDLE T. LAST Bartnik, Sr.		15. MOTHER'S MAIDEN NAME FIRST Anita MIDDLE B. LAST Blair			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-50-0148		17. INFORMANT 4013 Walrad St. Balto., Md. Mrs. Anita B. Bartnik #21229	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC ACTIVE HEPATITIS 5714 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 YR
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CIRRHOSIS OF LIVER, ASCITES					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 5/1 , 19 80 , to 19 87 , that (I) (we) last saw the deceased alive on 29 JAN , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Walter J. Alt, MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER J ALT, MD		22e. ADDRESS 301 MARYDELL RD BALTIMORE MD 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-21-84		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. Balto. Md.	
24. FUNERAL DIRECTOR G. Trauman Schwab		5151 Balto. Nat'l. Pike #21229		25a. DATE REC'D. BY REGISTRAR JAN 24 1984	
25b. REGISTRAR'S SIGNATURE John J. Gentry					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100-100000

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

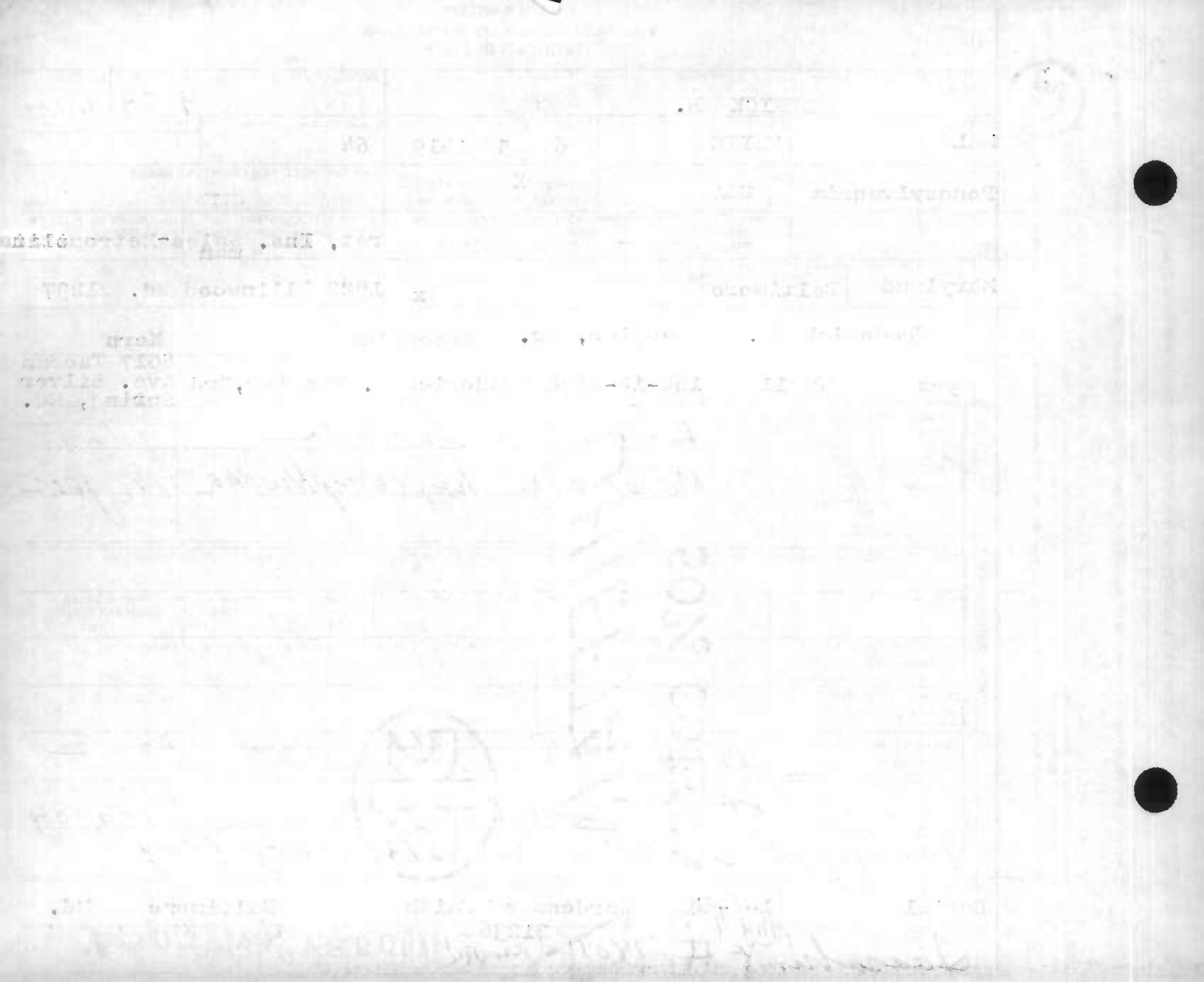
1. DECEASED NAME (TYPE OR PRINT) FREDERICK M. BASGIER			2a. DATE OF DEATH MONTH DAY YEAR 1 4 84 2b. HOUR 9.10 AM		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 6 5 1919	6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. MONTHS DAYS		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ret. Ins. Sales-Metropolitan		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 1922 Ellinwood Rd. 21237		
14. FATHER'S NAME FIRST MIDDLE LAST Frederick M. Basgier, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Kern		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes	
16b. SOCIAL SECURITY NO. WW 11		17. INFORMANT Frederick M. Basgier, 3rd		ADDRESS 8017 Tacoma Ave. Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic hypernephroma DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 1 1/2 year					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/17 , 19 83 , to 1/4 , 19 84 , that (I) (we) last saw the deceased alive on 1/4/84 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Evangelos LIGNOS		DEGREE M.D.		22c. DATE SIGNED 1-4-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Evangelos LIGNOS		22e. ADDRESS 201 E. University Pkwy			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-6-84		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		23e. DATE REC'D. BY REGISTRAR 24236			
24. FUNERAL DIRECTOR NAME Laeschin & H		ADDRESS 7401 Bakers Rd		25. DATE REC'D. BY REGISTRAR 9 1984	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

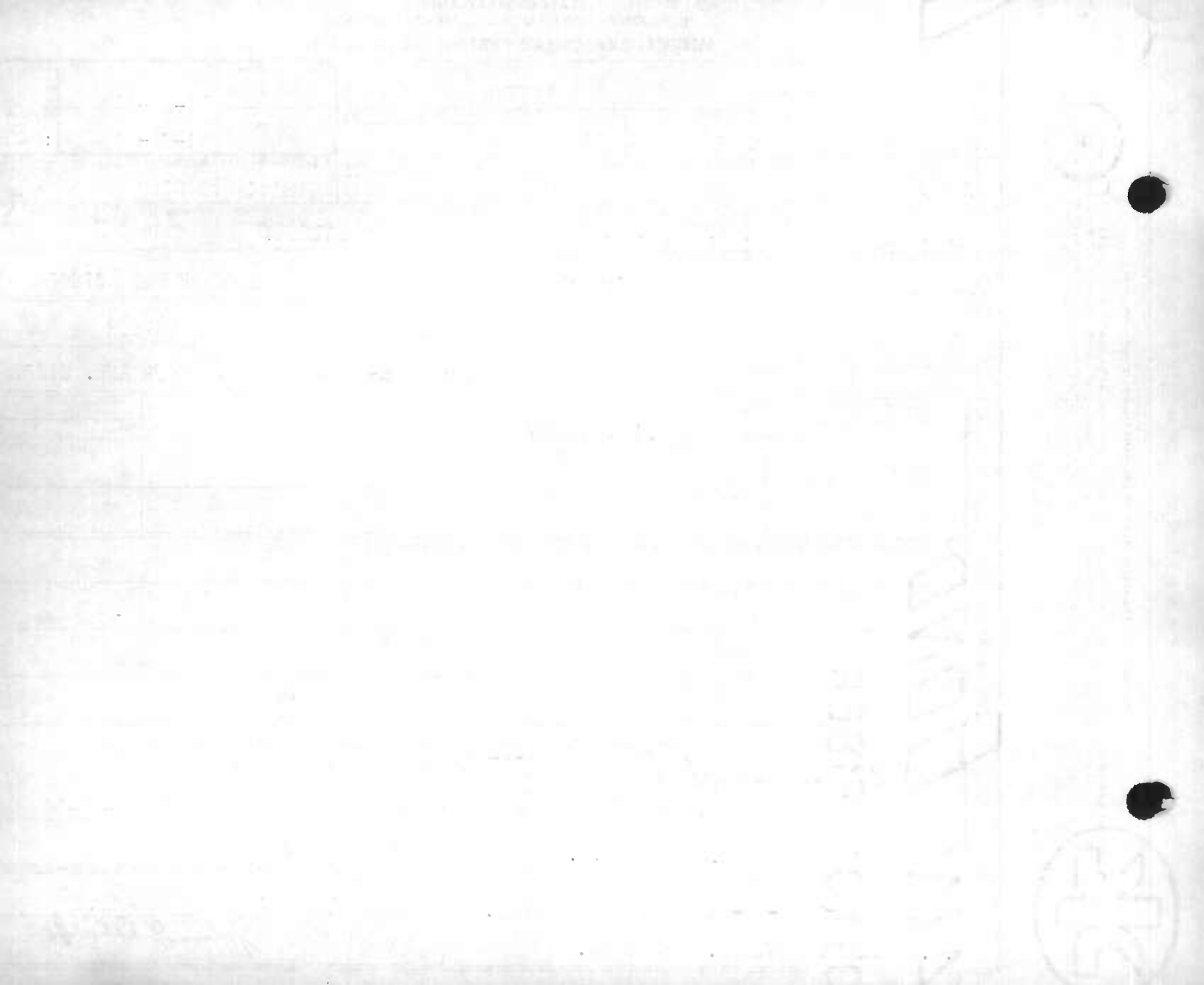


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARSON BATTLE										2a. DATE KNOWN OF DEATH ESTIMATED XX 1-24-84 ¹⁹					2b. HOUR M 1:04A												
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 5 18 68		6. AGE (IN YEARS LAST BIRTHDAY) 15 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 1-24-84 ¹⁹					2d. HOUR M 1:04A										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? US				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.															
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT				12b. KIND OF BUSINESS OR INDUSTRY															
13a. STATE MARYLAND				13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5221 PEMBROOK AVENUE 21207																	
14. FATHER'S NAME FIRST MIDDLE LAST CLARENCE BATTLE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PHYLISS TAYLOR				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO												16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS PHYLISS HAWKINS 5221 PEMBROOK AVE. 21207			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4254 IMMEDIATE CAUSE (a). <u>Cardiomyopathy</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 1-25-84													
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1-28-84		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMT.				23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND																	
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS				ADDRESS 1721 N. MONROE ST.				25a. DATE REC'D. BY REGISTRAR JAN 30 1984				25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>															



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT RICHARD BAYLOR			2a. DATE OF DEATH MONTH DAY YEAR 01 02 84		2b. HOUR 2:50P
3 SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 5 16 33		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3503 Fairview Ave. 21216
14. FATHER'S NAME FIRST MIDDLE LAST Gilliam Baylor		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ann Beasley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES		16b. SOCIAL SECURITY NO. 215-20-4352		17. INFORMANT ADDRESS Robert Biscoe Charlotte, N.C. 1409 Falcon St.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 minutes 2 weeks
---	--	--

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **no**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (if this hospital) attended the deceased from 12/26 , 19 83 , to 1/2 , 19 84 , that (if we) last saw the deceased alive on 1/2 , 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (if we) did not view the body after death.					
22b. SIGNATURE E Streeten MD				22c. DATE SIGNED 1/2/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E Streeten MD				22e. ADDRESS Johns Hopkins Hospital	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1/6/84	23c. NAME OF CEMETERY OR CREMATORY Mount Zion Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Lansdowne, Md.
--	----------------------------	--	---

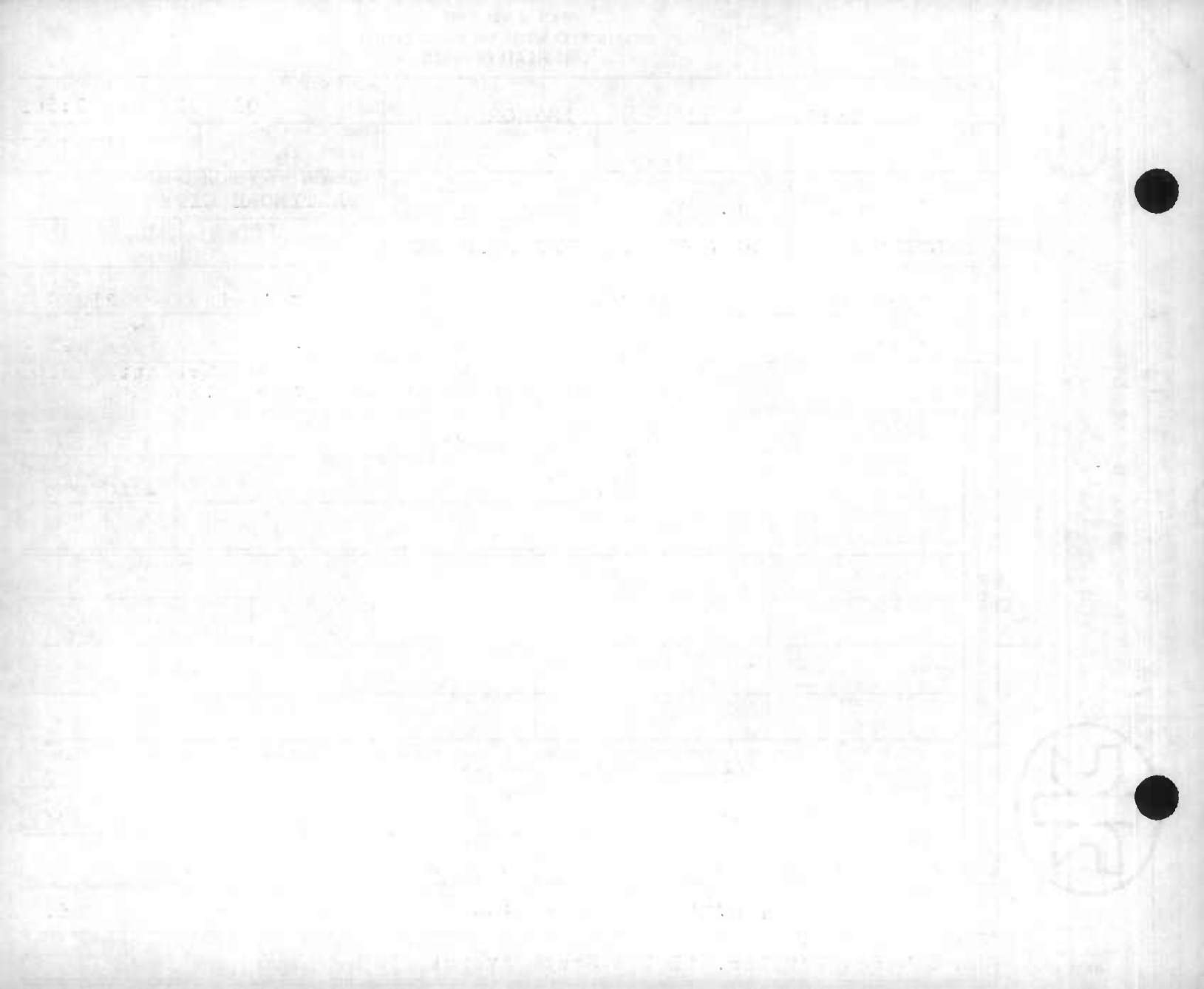
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc. 1101 E North Avenue	25a. DATE REC'D BY REGISTRAR JAN 6 1984	25b. REGISTRAR'S SIGNATURE John J. Smith
--	---	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.							
1. FOR STATE REGISTRAR				7. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) ^{FIRST} <u>GEORGE</u> ^{MIDDLE} <u>F.</u> ^{LAST} <u>BEALL</u>				1 19 84				8:45 AM			
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>January 3, 1899</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>85</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.					
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Union Memorial Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Defense Dep't.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE <u>4 E. 32nd Street 21218</u>			
13a. STATE <u>Maryland</u>		13b. COUNTY		13c. CITY OR TOWN <u>Baltimore</u>							
14. FATHER'S NAME ^{FIRST} <u>Bertram</u> ^{MIDDLE} <u>A.</u> ^{LAST} <u>Beall</u>				15. MOTHER'S MAIDEN NAME ^{FIRST} <u>Lucy</u> ^{MIDDLE} <u>unknown</u> ^{LAST}							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u> (IF YES, GIVE WAR OR DATES) <u>WW I</u>				16b. SOCIAL SECURITY NO. <u>218-10-5954</u>		17. INFORMANT ADDRESS <u>Ellicott City, Md.</u> <u>Joel E. Brown 3622 Windfall Terrace 21043</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4360</u> IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>STROKE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>COPD</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/24</u> , 19 <u>83</u> , to <u>1/14</u> , 19 <u>84</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>1/13</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>David S. Dunn</u>				DEGREE				22c. DATE SIGNED <u>1/14/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DAVID S. DUNN</u>				22e. ADDRESS <u>201 E. University Pkwy</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>1-16-1984</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley</u>		23d. LOCATION <u>Cockeysville</u> COUNTY <u>Maryland</u>			
24. FUNERAL DIRECTOR NAME <u>Ruck Towson Funeral Home, Inc.</u> ADDRESS <u>1050 York Road Towson, Maryland</u>				25a. DATE REC'D. BY REGISTRAR <u>JAN 17 1984</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>					

RECEIVED
OFFICE OF THE
ATTORNEY GENERAL
WASHINGTON, D.C.

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

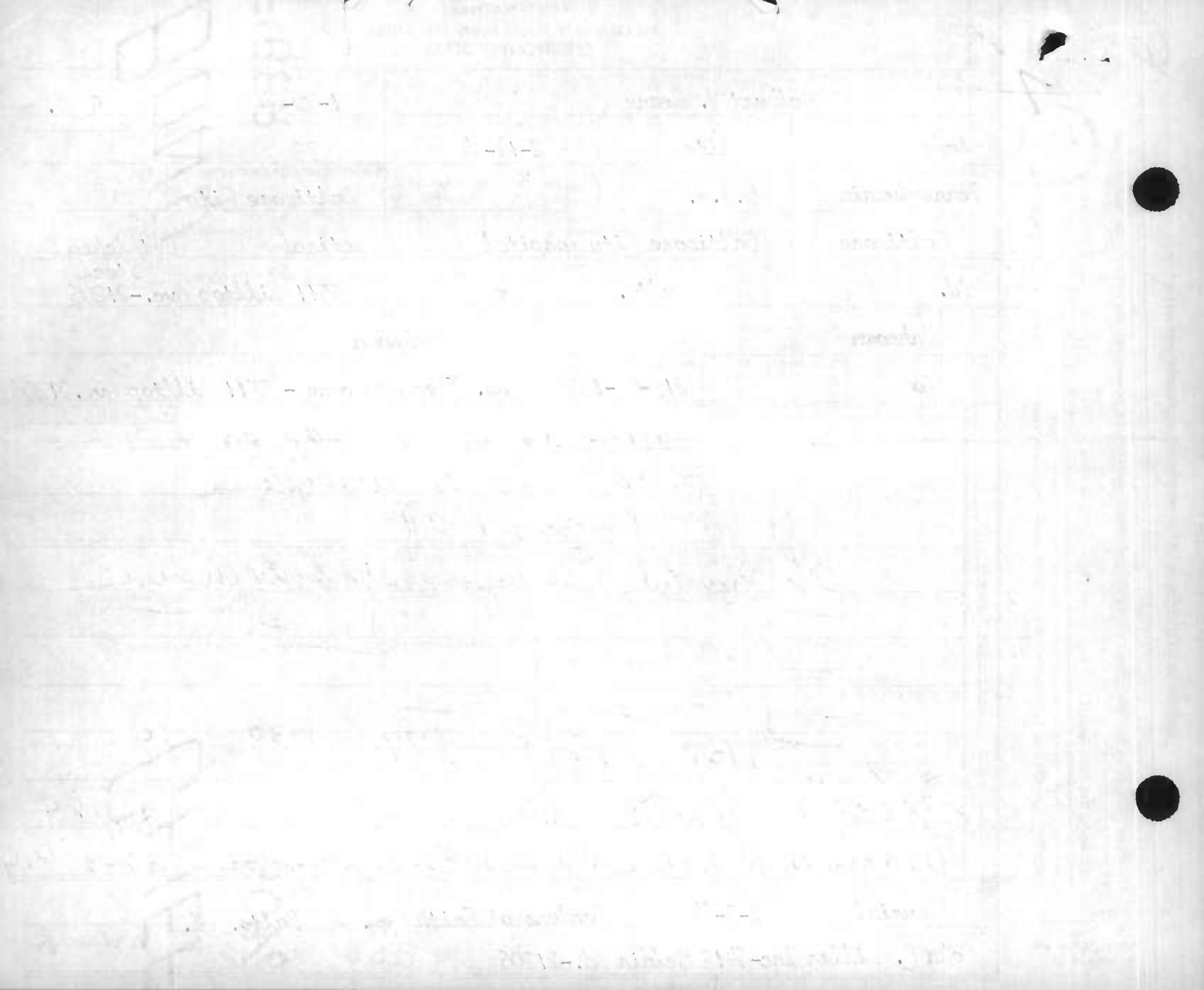
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (LAST OR PRINT) <i>Delbert V. Beane</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>1-30-84</i>			
3 SEX <i>Male</i>				4 RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2-14-04</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS		8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>79</i>	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT INSURE FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospital</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.		12b. KIND OF BUSINESS OR INDUSTRY <i>Bethlehem</i>	
13a. STATE <i>MD.</i>				13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Balto.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Unknown</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Unknown</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>213-07-1598</i>		17. INFORMANT ADDRESS <i>Mrs. Theresa Beane - 5511 Hilltop Ave. 21206</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute MI & Cardiac arrest</i> <i>4100</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>AS CD - oed MI - arrhythmia</i> (c) <i>anatomical CHF.</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Ch Bndul Hypertension + abd & other disease</i>							
19a. DATE OF OPERATION <i>2/9</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ch Bndul Hypertension + abd & other disease</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OR INJURY IN ITEM 18, PART I OR PART 2) <i>Ch Bndul Hypertension + abd & other disease</i>			
22a. I certify that (I) (the hospital) attended the deceased from <i>1/21</i> 19 <i>84</i> , to <i>1/30</i> 19 <i>84</i> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>Donald W. Mintzer MD.</i>		22c. DATE SIGNED <i>2/1/84</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DONALD W. MINTZER MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2-3-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>John C. Miller Inc-6415 Belair Rd.-21206</i>				25a. DATE REC'D BY REGISTRAR <i>FEB 6 1984</i>			
25b. REGISTRAR'S SIGNATURE <i>John C. Miller</i>				25c. REGISTRAR'S SIGNATURE <i>John C. Miller</i>			

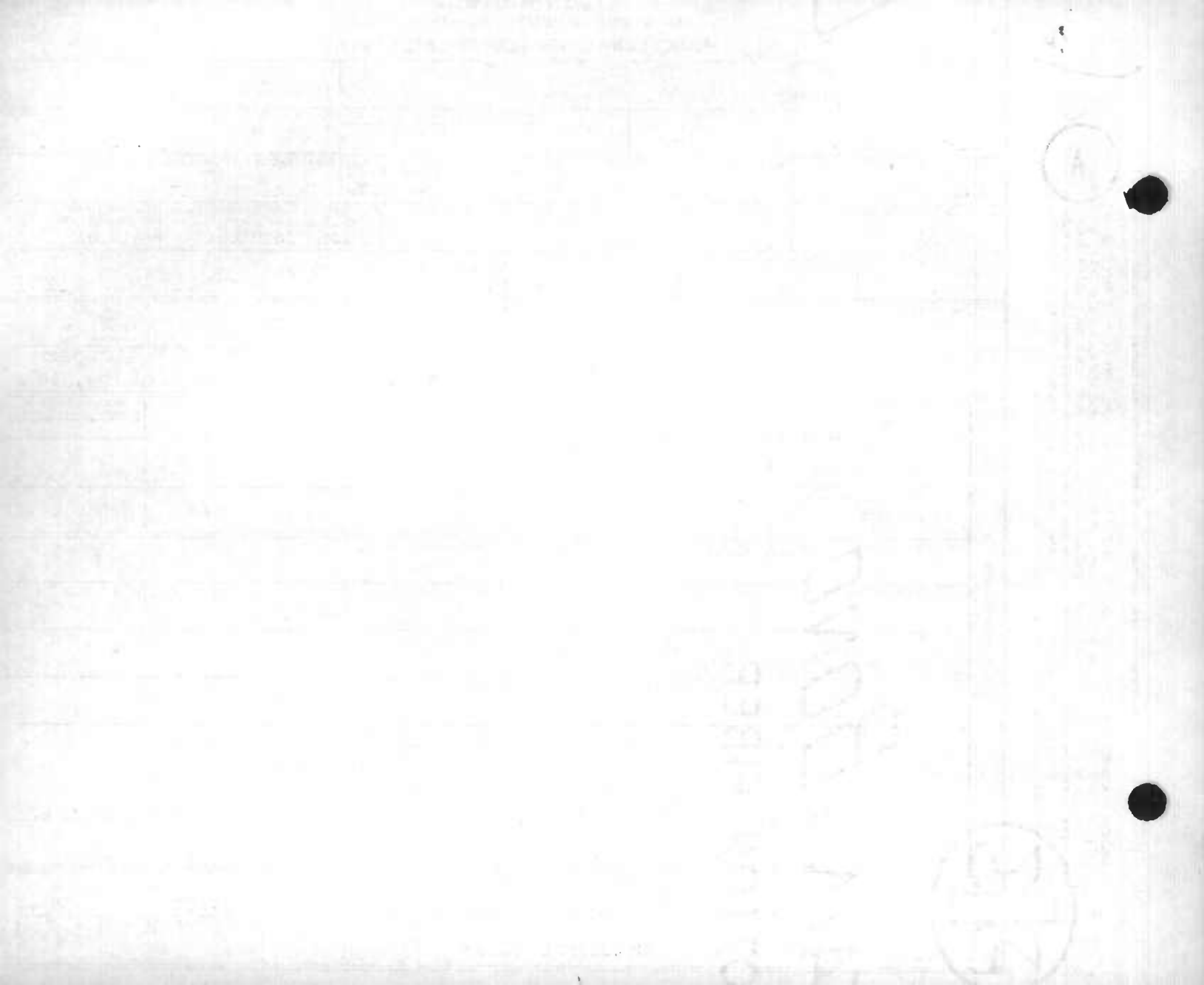
BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 000139	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
Sydney C. Beaudry								1/22/84		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Male	Cau.	7 9 28		55 YRS.		MONTHS DAYS HOURS MIN.				1/22/84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		2d. HOUR	
Canada		U.S.A.						Baltimore City		8:53 P M	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		306 W. Franklin St.				Food Service		Chef			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		306 W. Franklin St. 21201			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
Ludger A. Beaudry				Suzanne Anna Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		261-58-7607		Louis S. Beaudry Gaithersburg, Md.		873 Clopper Rd					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>											
4292 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							
20. AUTOPSY?											
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Margarita A. Korell				M.D. Assistant MEDICAL EXAMINER				1/24/84			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Margarita A. Korell, M.D.				111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE	
Cremation				1-28-84		Security Process Inc		Baltimore		Md.	
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
MacNabb Funeral Home				Catonsville, Md		FEB 3 1984					

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) MARY CORDELIA BECKER					2a. DATE OF DEATH MONTH DAY YEAR JANUARY 19, 1984		2b. HOUR 6:45 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 8 1884		6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Edgewood Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13e. STREET ADDRESS 3003 St. Paul St.			
14. FATHER'S NAME FIRST MIDDLE LAST Lambert Hilon Pollitt					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Permelia Ann Steirs				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-03-2989		17. INFORMANT Sister:		ADDRESS 21228 Leora M. Doroba, Caton Manor, Catonsville, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Disease post stroke DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 5 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6-24 , 19 77 , to Jan 19 , 19 84 , that (I) (we) last saw the deceased alive on Jan 17 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Frederick J. Vollmer, M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1-20-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick J. Vollmer, M.D.					22e. ADDRESS 6100 York Rd. Baltimore, Md. 21212				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/23/84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland			
24. FUNERAL DIRECTOR STEWART & MOWEN CO., 108 W. North Ave. 21201					25. DATE RECEIVED BY REGISTRAR JAN 23 1984		25b. REGISTRAR'S SIGNATURE John J. Conner		

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows]

RE: [Illegible]
[Illegible text follows]

[Extremely faint and mostly illegible text block containing several paragraphs of a memorandum or report.]

CHIEF

20% COPY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dorothy T. Bem			2a. DATE OF DEATH MONTH DAY YEAR 1 16 1984		2b. HOUR 3:30 P		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 14 1924		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Martin H. Walter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Lauterbach		13e. STREET ADDRESS / ZIP CODE 203 North Branch Road 21222			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 219-12-7363		17. INFORMANT Joseph A. Bem		ADDRESS 203 North Branch Road Baltimore, MD 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u> <u>1991</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Small cell Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3</u> 19 <u>83</u> to <u>12</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>12</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Myo Thant</u>		DEGREE M.D.		22c. ADDRESS 9101 FRANKLIN SQ-DR BALTO, MD 21237		22d. DATE SIGNED 1/17/84	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) MYO THANT		22f. ADDRESS Thant, M.D.		22g. ADDRESS 9101 FRANKLIN SQ-DR BALTO, MD 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1/19/84		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue, Dundalk, MD 21222				25a. DATE REC'D. BY REGISTRAR JAN 19 1984		25b. REGISTRAR'S SIGNATURE	

BP

Items 18-22a mth 3/12/84 P#589

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

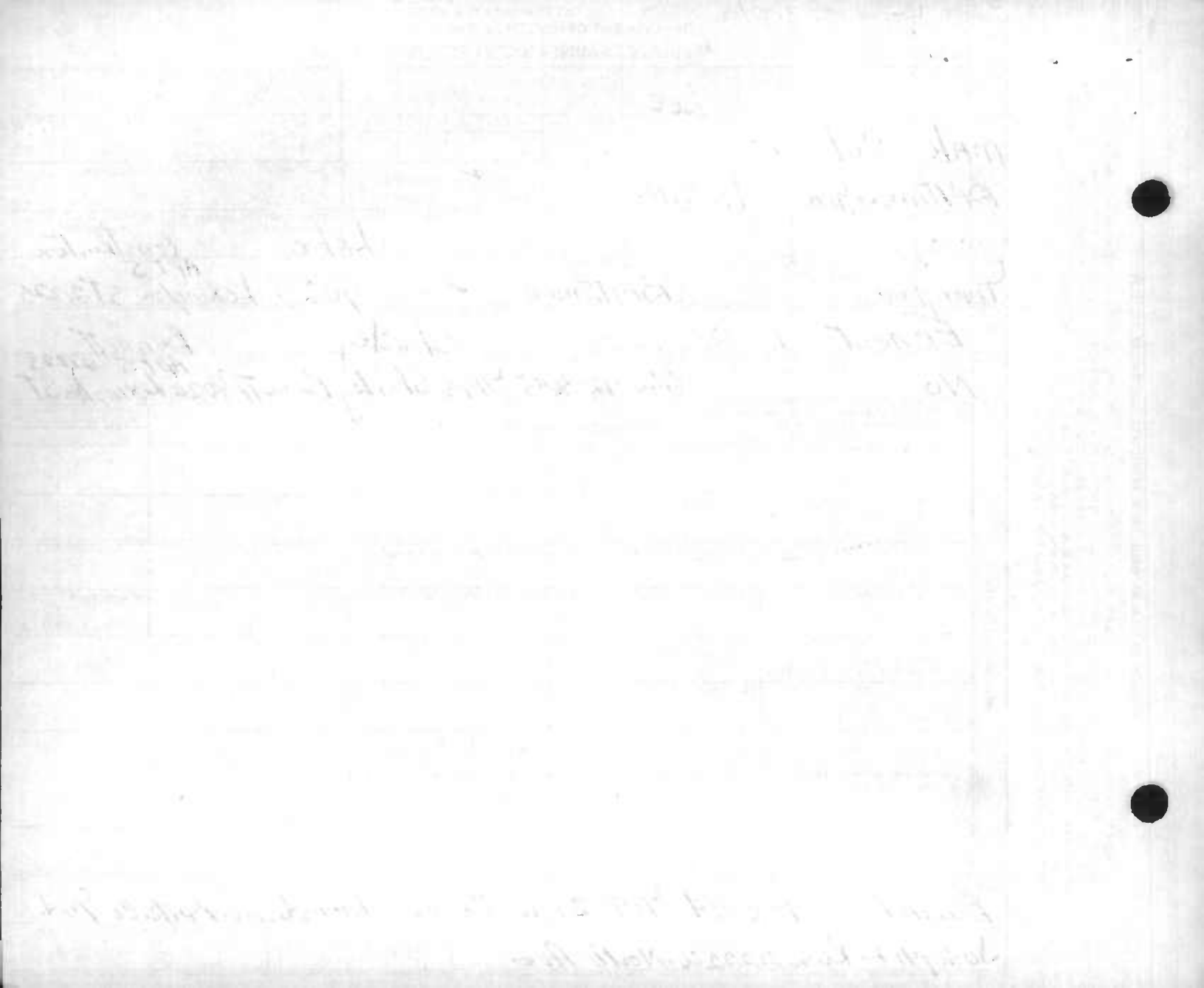
000742

FOR
1- STATE
REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		Ernest Lee Bennett		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 1/5/84 19		2b. HOUR M 10:36 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 1/5/84 19	
male	Col	12-6-54	29 YRS.				
7a. BIRTHPLACE (STATE OR TERRITORY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Baltimore Md		U.S.A.				Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		902 W. Lexington St. Apt. 5		Labor		Construction	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Baltimore				902 W. Lexington St 21223	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Ernest L. SCOVNES		Shirley Bennett		No		220-12-3645	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Mrs. Shirley Bennett		Apt 5 21223 902 W. Lexington St		PART 1 DEATH WAS CAUSED BY: Intravenous Narcotism			
				IMMEDIATE CAUSE (a) 3049			
				DUE TO, OR AS A CONSEQUENCE OF			
				(b)			
				DUE TO, OR AS A CONSEQUENCE OF			
				(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED			
Dennis F. Smyth, M.D.		Assistant		1/5/84			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Dennis F. Smyth, M.D.		111 Penn St., Balto., Md. 21201		Burial		1-10-84	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Joseph L. Russ		2222 W. North Ave.		JAN 12 1984		John J. Lawick	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Mt. Zion Cem.		Towson Baltimore Co Md.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST LAST William Bennis		MONTH DAY YEAR 1/2/84	
3. SEX MALE		2b. HOUR 940 AM	
4. RACE Black		6. AGE (IN YEARS LAST BIRTHDAY)	
5. DATE OF BIRTH MONTH DAY YEAR 10 23 06		7. IF UNDER 1 YEAR MONTHS DAYS 79 YRS.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lincoln Convalescent Center	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		13b. COUNTY BALTO	
14. FATHER'S NAME FIRST MIDDLE LAST William Bennis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LeHie Bishop	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.	
17. INFORMANT William Gross		ADDRESS 3709 Dennys Rd 21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cardiovascular disease Senile dementia DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 6/1		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 517 SCOTT ST BALTO MD 21230	
22a. I certify that (I) (this hospital) attended the deceased from 12/28 1983, to 1/2 1984, that (I) (we) last saw the deceased alive on 12/28 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE Kuang-yen Huang MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED 1/2/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KUANG-YEN HUANG		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-7-84	
23c. NAME OF CEMETERY OR CREMATORY Mt Auburn		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.	
24. FUNERAL DIRECTOR NAME JOSEPH L. RUSS		25a. DATE REC'D. BY REGISTRAR JAN 12 1984	
ADDRESS 2222 W. NORTH AVE.		25b. REGISTRAR'S SIGNATURE John J. Lauer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR BESSIE MARRIAN BENNY					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Bessie MARRIAN Benny					2a. DATE OF DEATH MONTH 1 DAY 3 YEAR 84			2b. HOUR 6:20 A.M.	
3. SEX FEMALE		4. RACE WHITE XXXX		5. DATE OF BIRTH MONTH 2 DAY 25 YEAR 1893		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MUIRKIRK, MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1904 MONROE ROAD 21222		
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN DUNDALK					
14. FATHER'S NAME FIRST BENJAMIN MIDDLE PHELPS LAST JONES				15. MOTHER'S MAIDEN NAME FIRST ROSE MIDDLE JONES LAST JONES					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215.24.3415		17. INFORMANT ADDRESS ELMA B. HILGARTNER 11964 PARK HEIGHTS AVE. OWINGS MILLS, MD 21117					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): myocardial Infarction									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/15 , 19 84 , to 1/3 , 19 84 , that (I) (we) lost saw the deceased alive on 1/3 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. [Signature]				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/3/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. [Signature]				22e. ADDRESS Mercy Hospital					
23a. CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/6/1984		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD			
24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, INC.				ADDRESS DUNDALK, MD		25a. DATE REC'D. BY REGISTRAR JAN 4 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

W. H. M. A. B. B. B.

10

CO
H
V
A
F
I
N

308 91001 803

MA
C
H
N
E

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 / 4 5

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SHIRLEY			FIRST MIDDLE LAST BERMAN			2a. DATE OF DEATH MONTH DAY YEAR 1-4-84				2b. HOUR 5:09 P.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7 12 04		6. AGE (IN YEARS LAST BIRTHDAY) 79 80 YRS.				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.					
10. CITY OR TOWN OF DEATH BALTO CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESWOMEN/BUYER				12b. KIND OF BUSINESS OR INDUSTRY TRUFIT CO.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5905 WINNER AVE. #2125			
14. FATHER'S NAME FIRST MIDDLE LAST DAVID GREENBAUM						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLIE GROLLMAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-076785		17. INFORMANT LEONARD BERMAN				APT. A-1 3600 LABYRINTH RD. BALTO., MD 21215			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Inferior Wall 4/100 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF (c) Cardio Genic Shock		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/27 , 19 83 , to 1/4 , 19 84 , that (I) (we) last saw the deceased alive on 1/4 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bernard F. Koblorsky				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/5/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bernard F. Koblorsky				22e. ADDRESS B/O SINAI HOSP. BALTO., MD.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 6, 1984		23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO		23d. LOCATION BALTIMORE COUNTY MARYLAND	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR JAN 10 1984		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

BOX COTTON

CHAMPAIN



Handwritten text, likely a signature or address, appearing as 'Wm. H. ...' and '...'

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 4 0 0 7 4 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Maxwell Bernstein			2a. DATE OF DEATH MONTH 1 DAY 1 YEAR 1984		2b. HOUR 4:45 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 12 DAY 10 YEAR 1910	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, MD		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LAYOUT MAN		12b. KIND OF BUSINESS OR INDUSTRY PRINTING SHOP
13a. STATE MD		13b. COUNTY Baltimore	13c. STREET ADDRESS 2611-D GAGE CT.		13d. CITY OR TOWN BALTO., MD
14. FATHER'S NAME FIRST JACOB MIDDLE BERNSTEIN LAST BERNSTEIN		15. MOTHER'S MAIDEN NAME FIRST SARAH MIDDLE UNKNOWN LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-01-8267		17. INFORMANT MRS. ANNE BERNSTEIN	
		2611-D GAGE CT.		21209	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1850

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) **Intracranial bleed & Craniotomy**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Metastatic prostate Cancer**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

Clostridial Colitis

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/29 19 83 to 1/1 19 84 , that (I) (we) lost saw the deceased alive on 1/1/84 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R E Perry MD		DEGREE		22c. DATE SIGNED 1/1/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R E Perry MD		22e. ADDRESS Sinai Hospital Baltimore, MD 21205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE JAN. 3, 1984	23c. NAME OF CEMETERY OR CREMATORY MOSES MONTEFIORE WOODMOOR HEBREW		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR JAN 5 1984		25b. REGISTRAR'S SIGNATURE John J. Caruth	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

BP

DHMH-16 30M 2/80
(VRA 15, 4)

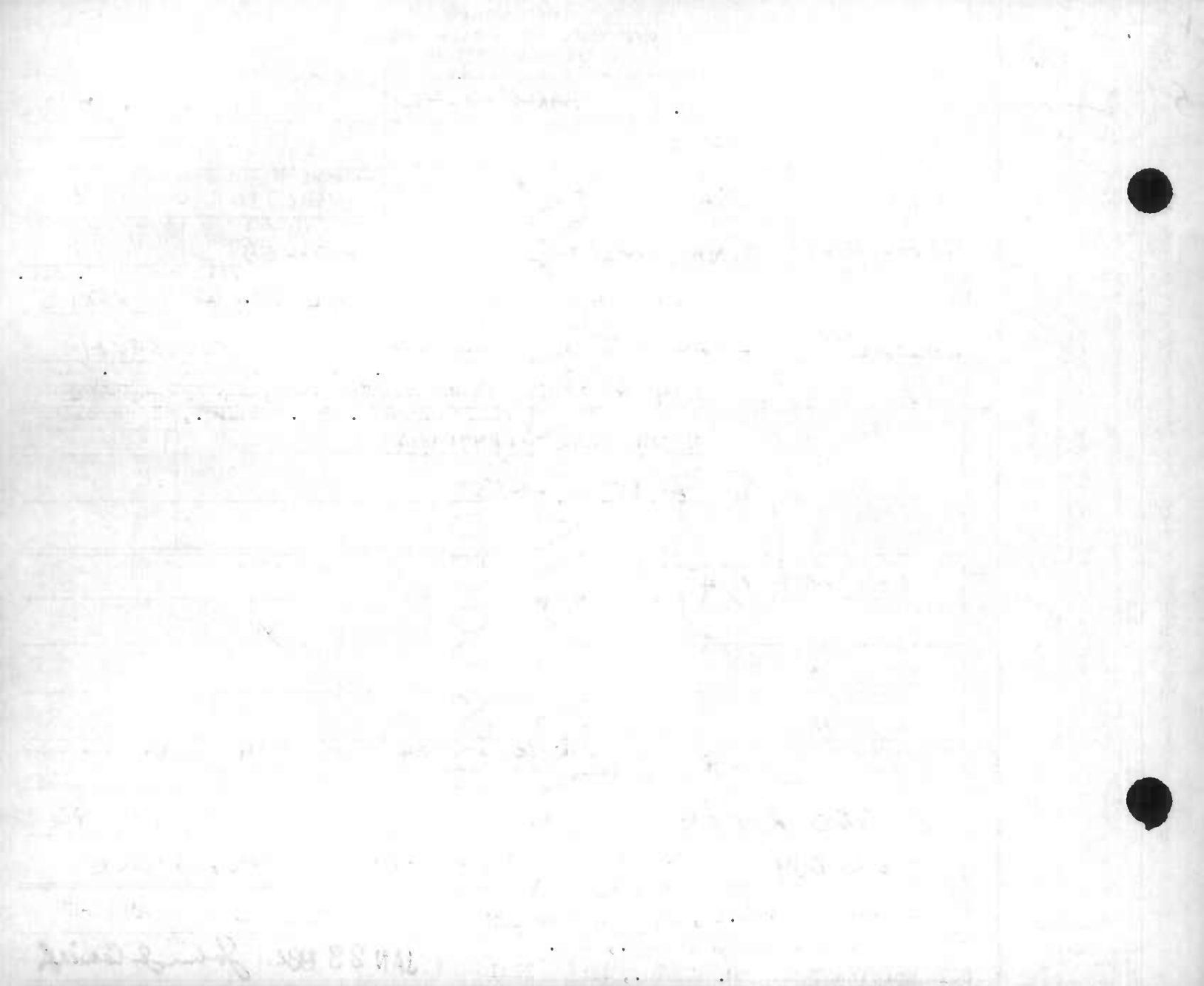
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked children, it shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8400747	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				REG. NO.	
FIRST SOL		MIDDLE C.	LAST BERENHOLTZ		2a. DATE OF DEATH MONTH DAY YEAR 1-14-84
3. SEX MALE		4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 9 16 02		2b. HOUR 10:20 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
12a. USUAL RESIDENCE (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY AT LAW		12c. ADDRESS 7111 PARK HTS. AVE. PARK TOWERS 21215	
13a. STATE Md		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HASKILL BERENHOLTZ		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNY NUSBAUM		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 214-38-6596		17. INFORMANT MRS. SONIA BERENHOLTZ APT. 511		17b. ADDRESS 7111 PARK HTS. AVE. BALTO., MD 21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR ARRYTHMIA 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION, ARDS. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Prob. PNEUMONIA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 1-10-84, 1984, to 1-14-84, 1984, that (I) (we) last saw the deceased alive on 1-14-84, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Susha Reddy		DEGREE MD		22c. DATE SIGNED 1-14-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.A. REDDY		22e. ADDRESS SINAI HOSP. OF BALTIMORE		22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 16, 1984		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH	
23d. LOCATION CITY OR TOWN COUNTY BALTIMORE MARYLAND		24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215			
25a. DATE REC'D. BY REGISTRAR JAN 23 1984		25b. REGISTRAR'S SIGNATURE John J. Canich			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST	MIDDLE	LAST	MONTH	DAY	YEAR	MONTH		DAY
Spencer Leon Berry			January 14, 1984			5:11 PM		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
M	Black	MONTH DAY YEAR 6 12 16		67 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Dinner 2010 24	USA				Baltimore City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Maryland General Hospital			Laborer Construction			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD			Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
Leon Benny			Gentle Cox		3015 Brookfield St			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
No			227-07-0584		Harrie Benny - Persons Bldg 14			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5401 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septic Shock</u>		Minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Hours
(c) <u>Bilateral Pneumonia</u>		Days

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
December 31, 1983		Appendiceal Abscess		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from December 29, 19 83, to January 14, 19 84, that (X) (we) lost saw the deceased alive on January 14, 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (didn't) view the body after death.							
22b. SIGNATURE Joseph E. Piszczek MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED January 14, 19	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Piszczek, M.D.				22e. ADDRESS C/o Maryland General Hospital			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Buried		1/16/84		Dinner 2010 24		Petersons Bldg 14	
24. FUNERAL DIRECTOR Blond R/H Petersons Bldg 14				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				JAN 20 1984			

THE UNIVERSITY OF CHICAGO
LIBRARY



CHIEF
M

20% COPIES



11

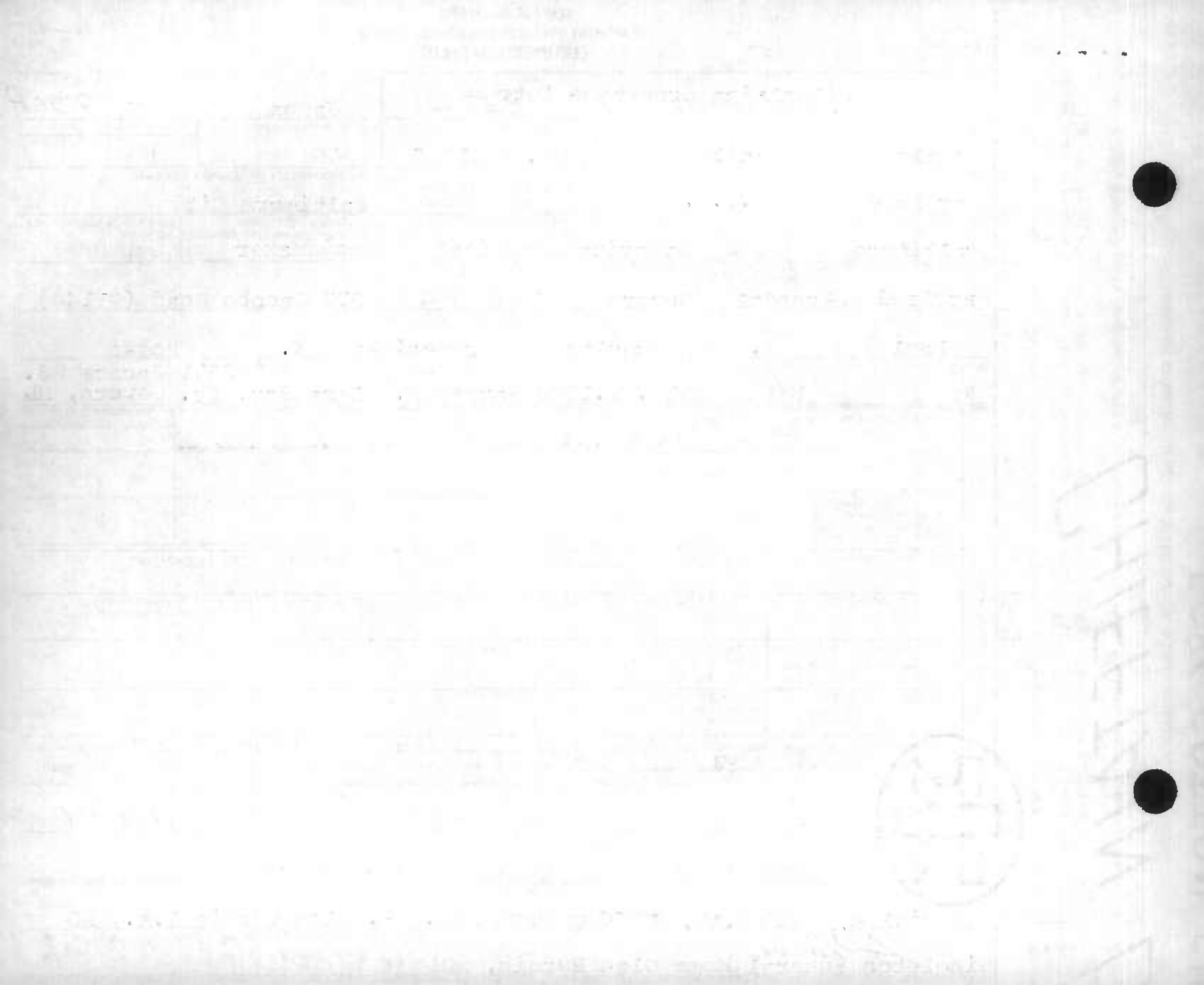
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8400749

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Wilhelmina Ernestine Betz		2a. DATE OF DEATH MONTH DAY YEAR January 8, 1984	
3 SEX Female		2b. HOUR 2:25 P	
4 RACE White		6. AGE (IN YEARS (LAST BIRTHDAY)) 78 YRS.	
5. DATE OF BIRTH MONTH DAY YEAR Sept. 28, 1905		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
7b. CITIZEN OF WHAT COUNTRY? U.S.A.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
10. CITY OR TOWN OF DEATH Baltimore		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital		13a. STREET ADDRESS 8377 Jacobs Road (21144)	
13a. STATE Maryland		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13c. COUNTY Anne Arundel		13d. CITY OR TOWN Severn	
14. FATHER'S NAME FIRST MIDDLE LAST Paul R. Schultz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fredericka K. Roese	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213.22.1994	
17. INFORMANT (son) ADDRESS 8371 Jacobs Rd. Barney E. Alexander, Sr. Severn, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1749 Metastatic heart cancer - hypercalcemia IMMEDIATE CAUSE (a) Metastatic heart cancer - hypercalcemia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/7 , 19 84 , to 1/8 , 19 84 , that (I) (we) lost saw the deceased alive on 1/8 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.			
22b. SIGNATURE [Signature]		22c. DATE SIGNED 1/8/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES H. MERSEY		22e. ADDRESS GOOD SAMARITAN HOSP.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 11, 84	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A., MD	
24. FUNERAL DIRECTOR NAME [Signature] ADDRESS Singleton Funeral Home Glen Burnie, MD		25a. DATE REC'D. BY REGISTRAR JAN 10 1984	
		25b. REGISTRAR'S SIGNATURE [Signature]	

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	4	0	0	7	5	0			
FOR 1 - STATE REGISTRAR										CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH									
FIRST MIDDLE LAST FANNIE Francis Bey										MONTH DAY YEAR HOUR 1 25 84 545 A									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.					
Female			Black			MONTH DAY YEAR 4 30 1908			75 YRS.			MONTHS DAYS		HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Virginia			U. S. A.						Baltimore City MD.										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Baltimore			Saint Agnes Hospital							Domestic Work - Retired									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?									
13a. STATE										13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland												Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2810 West North Ave. 21216			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST Robert Cole										FIRST MIDDLE EAST Elsie Bey									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b. SOCIAL SECURITY NO.			17. INFORMANT				ADDRESS		
No										216 05 7129			Elsie Bey				3308 Logate Road		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4280 Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)													
			HOUR A.M. MONTH DAY YEAR P.M. 19																
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION													
WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK						STREET			CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 1-7 , 19 84 , to 1-25 , 19 84 , that (I) (we) lost saw the deceased alive on 1-25 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE										DEGREE			22c. DATE SIGNED						
Qui Dien Huynh													1-25-84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS									
QUI DIEN HUYNH										ST AGNES HOSP - CATON AV - BALTO - MD 21229									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION										
Burial			1/28/84			Maryland Nat. Mem. Pk			CITY OR TOWN COUNTY STATE Laurel Maryland										
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Nutter and Sons Funeral Home, Inc.										2501 Gwynns Falls Pkwy. Baltimore, Md. - 21216			JAN 27 1984						
													John J. Coarish						

BP

Maryland

Maryland Nat. H. & L. Survey

1/28/84

Serial

2501 Gwyns Falls Hwy.
Baltimore, Md. - 21218

Butter and Sons
General Home, Inc.

2101 N. 11th St. Baltimore, Md. 21218

Robert

Baltimore

2101 West North Ave.

Saint James Hospital

Domestic Work - Retired

Baltimore City

U. S. A.

Virginia

Alaska

1908

75

Francis

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84 00751

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Emma Frances Bichell			2a. DATE OF DEATH MONTH DAY YEAR January 21 1984		2b. HOUR 8:02 A.M.		
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 4 1926		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1302 Edison Highway				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Opr.	
13a. STATE Md.		13b. CITY OR TOWN Baltimore		13c. STREET ADDRESS / ZIP CODE 1302 Edison Highway 21213		12b. KIND OF BUSINESS OR INDUSTRY Tasco Inc.	
14. FATHER'S NAME FIRST MIDDLE LAST unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-20-8151		17. INFORMANT ADDRESS Robert Bichell (son) 1940 Stanhope Rd 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Coronary artery thrombosis, probable DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Advanced Cancer, Vagina PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Recurrent Ca of vagina, fully treated							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James H. Dorsey M.D.				22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. James Dorsey	
22e. ADDRESS GMBC - 1st flr Radiology				22f. MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22g. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/24/84		23c. NAME OF CEMETERY OR CREMATORY Holy Cross		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213				25a. DATE REC'D. BY REGISTRAR JAN 24 1984		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "AT WORK" or "OTHER TRAUMATIC EVENT," the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then it should be returned to the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other violent event, the medical examiner must be notified.

MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 4 0 0 7 5 2			
1. DECEASED NAME Shawn Roger (TYPE OR PRINT)				LAST BICKSLER				2a. DATE OF DEATH MONTH DAY YEAR 01/10/84			
3. SEX Male				4. RACE White				5. DATE OF BIRTH MONTH DAY YEAR 1-6-1984			
6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 4				7. CITIZEN OF WHAT COUNTRY? U.S.A.				8. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD			
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Westminster				10. CITY OR TOWN OF DEATH BALTIMORE				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland				13b. COUNTY Carroll				13c. CITY OR TOWN Westminster			
14. FATHER'S NAME FIRST Roger MIDDLE William LAST Bickslr				15. MOTHER'S MAIDEN NAME FIRST Sandra MIDDLE Lavera LAST Sturdy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS Roger W. Bickslr Same as 53			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7581 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Complex Congenital Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) TRISOMY 13				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Renal Failure											
19a. DATE OF OPERATION N.A.				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N.A.				20a. AUTOPSY? PENDING YES <input type="checkbox"/> NO <input type="checkbox"/>			
20b. IF YES, IN CERTIFYING CAUSES OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>				21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N.A.			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N.A.				21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N.A.			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE N.A.				22a. I certify that (I) (this hospital) attended the deceased from Jan 6 , 19 84 , to Jan 10 , 19 84 , that (I) (we) lost saw the deceased alive on Jan 10 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE G. Karlowicz DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22c. DATE SIGNED 1/10/84				22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. KARLOWICZ				22e. ADDRESS JOHNS HOPKINS HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SP, CR, RM) Burial				23b. DATE 1-12-1984				23c. NAME OF CEMETERY OR CREMATORY Eugene M. Sanders			
23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg Carroll Md.				24. FUNERAL DIRECTOR NAME F.H. Fletcher ADDRESS 254 E. Main St. Westminster Md. 21157				25a. DATE REC'D. BY REGISTRAR JAN 17 1984			
25b. REGISTRAR'S SIGNATURE John J. Connel											

RECEIVED

RECEIVED

RECEIVED

WASHINGTON FIELD

RECEIVED

RECEIVED

RECEIVED

P8-311

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of 2 to be retained by the hospital or attending physician.

DHMH - 16 50M 1/81
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY THERESA BILLINGS				2a. DATE OF DEATH MONTH DAY YEAR 1 14 84		2b. HOUR 10⁵² P.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 01 07 26		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 58 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PACKING	
						12b. KIND OF BUSINESS OR INDUSTRY BAKERY	
13a. STATE MARYLAND		13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM E. CARLIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY J. REST		13e. STREET ADDRESS 2687 EAGLE STREET, 21223			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 220-12-7272		17. INFORMANT ADDRESS WILLIAM T. BILLINGS 2687 EAGLE ST., 21223			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarct 2500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Diabetic mellitus + hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Acute ileitis + septicemia 2° to gas forming bacillus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/14 19 84 to 7/14 19 84 , that (I) (we) last saw the deceased alive on 7/14 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William L. Hicken MD		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/15/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W J HICKEN, MD		22e. ADDRESS St Agnes Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 01-19-84		23c. NAME OF CEMETERY OR CREMATORY CREST LAWN MEM. GAR.		23d. LOCATION CITY OR TOWN COUNTY STATE MARRIOTTSTVILLE HOWARD MD.	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		ADDRESS 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR JAN 17 1984		25b. REGISTRAR'S SIGNATURE John J. Smith	

RECEIVED

PM

501 10 4 17-4 108

THE
UNITED STATES
DEPARTMENT OF
THE ARMY
WASHINGTON, D. C.
OFFICE OF THE
CHIEF OF STAFF
GENERAL STAFF
OFFICE OF THE
CHIEF OF STAFF
GENERAL STAFF

TO THE
CHIEF OF STAFF
GENERAL STAFF
OFFICE OF THE
CHIEF OF STAFF
GENERAL STAFF
OFFICE OF THE
CHIEF OF STAFF
GENERAL STAFF

THE
UNITED STATES
DEPARTMENT OF
THE ARMY
WASHINGTON, D. C.
OFFICE OF THE
CHIEF OF STAFF
GENERAL STAFF
OFFICE OF THE
CHIEF OF STAFF
GENERAL STAFF

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANK MNN BIRCHFIELD			2a. DATE OF DEATH MONTH DAY YEAR 1 14 84			2b. HOUR 6:50p m			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 7/4/16		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTO., MD. 21218				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCKING		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 427 S. TAYLOR AVE 21221	
14. FATHER'S NAME FIRST MIDDLE LAST UNK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) UNK		17. INFORMANT DOLORES BIRCHFIELD		ADDRESS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Cardio Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Anoxic Encephalopathy DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac Arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4D 4D	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Coronary artery disease, Ventricular arrhythmias									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from JANUARY 14, 1984, to JANUARY 14, 1984, that (we) lost saw the deceased alive on JANUARY 14, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.									
22b. SIGNATURE Clare Bradley MD			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/14/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Clare Bradley MD			22e. ADDRESS Lak Ravan V. A Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 1/17/84		23c. NAME OF CEMETERY OR CREMATORY SECURITY PROCESS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.		
24. FUNERAL DIRECTOR NAME J.G. CONNELLY			ADDRESS 300 MACE			25a. DATE REC'D. BY REGISTRAR JAN 20 1984		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

FILED



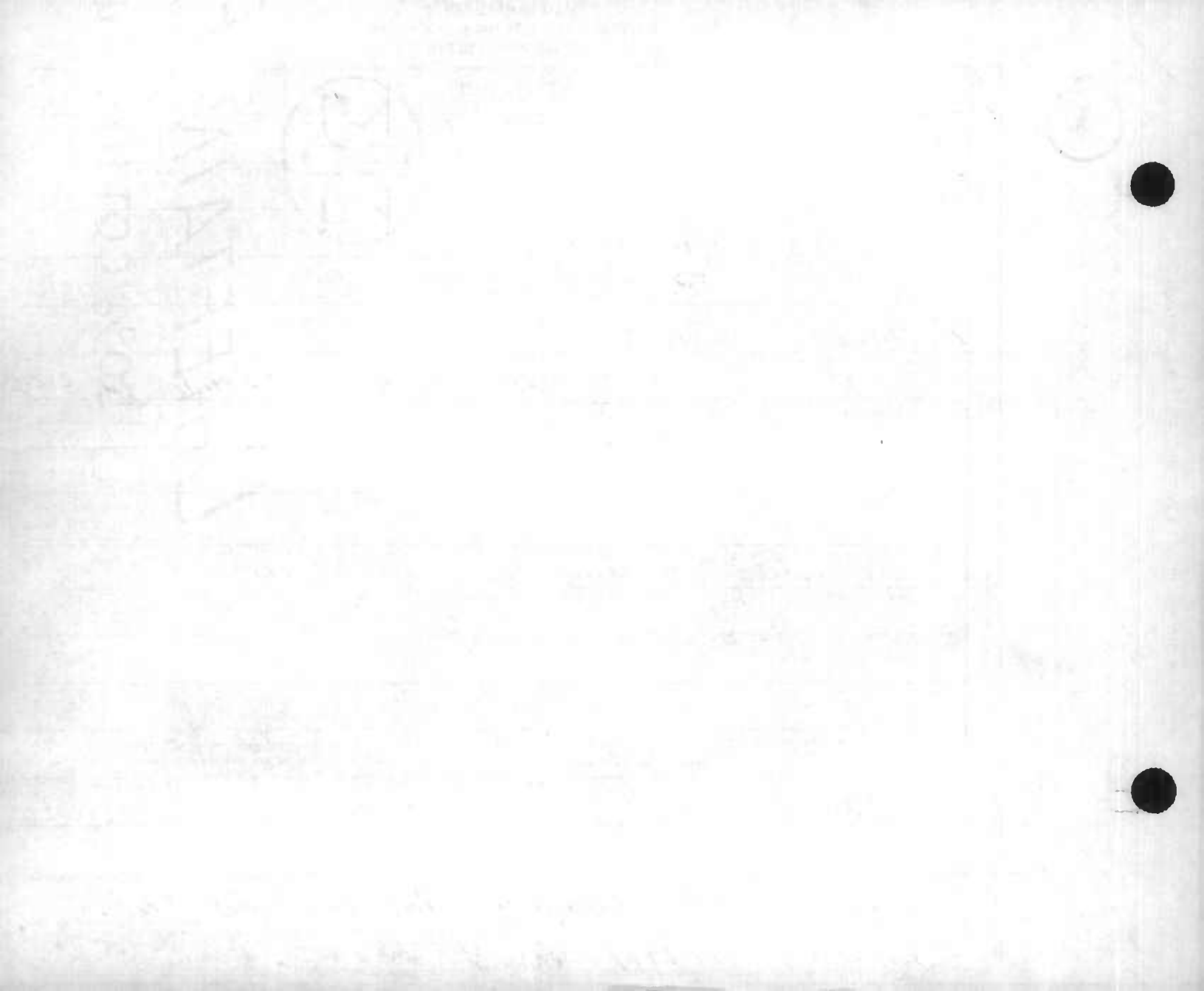
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 1 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 48 shows any injury, or other traumatic event, the medical certificate must be completed at 001.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) EFFIE BISHOP					2a. DATE OF DEATH MONTH 1 / DAY 8 / YEAR 84			2b. HOUR 1045 AM			
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH 12 / DAY 10 / YEAR 70		6. AGE (IN YEARS LAST BIRTHDAY) 73		IF UNDER 1 YEAR MONTHS 0 / DAYS 0		IF UNDER 24 HRS HOURS 0 / MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2911 London Ave - 21216 -			
14. FATHER'S NAME FIRST Richard MIDDLE Smith LAST Smith					15. MOTHER'S MAIDEN NAME FIRST Betty MIDDLE Smith LAST Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 4100		17. INFORMANT Betty Smith ADDRESS 2911 London Ave 21216							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive Anterior MI 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ASVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Aspiration pneumonia, cardiogenic shock											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1/5 , 19 84 , to 1/8 , 19 84 , that (I) (we) last saw the deceased alive on 1/8 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Uma Prasad				DEGREE				22c. DATE SIGNED 1/8/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 1/2/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cent.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.					
24. FUNERAL DIRECTOR NAME E.L. Phillips ADDRESS 1721-27 N. Monmouth St.				25a. DATE REC'D. BY REGISTRAR JAN 1 9 1984		25b. REGISTRAR'S SIGNATURE [Signature]					

BP.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Irene C. Bittner			2a. DATE OF DEATH MONTH DAY YEAR January 7, 1984			2b. HOUR 5:18 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 10, 1903		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 80		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN 21234		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8002 Ridgely Oak Rd. 21234	

14. FATHER'S NAME FIRST MIDDLE LAST Thomas F. Coughlin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes V.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-01-0154		
17. INFORMANT ADDRESS W.K. Winbigler Fort Washington, MD 20744					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5698 IMMEDIATE CAUSE (a) Congestive Heart Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO, OR AS A CONSEQUENCE OF (c) Peritonitis Probably Secondary to Colon Perforation			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Metastatic Adeno Carcinoma of the Colon

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from December 22, 1983 to January 7, 1984 , that (I) (we) lost 88 above (I) (we) did not view the body after death.							
22b. SIGNATURE Eric Fisher		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		18. DATE SIGNED 1/7/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric Fisher, M.D.				22e. ADDRESS c/o Maryland General Hospital			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 9, '84		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS William E. Johnson 8521 Loch Raven Blvd.				25a. DATE REC'D. BY REGISTRAR JAN 9 1984		25b. REGISTRAR'S SIGNATURE John J. Conner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

5-12	January 7, 1984	Bitter	Irma
	Baltimore City		
		Maryland General Hospital	Baltimore

Connective Heart Failure

Cereals

Peritonitis Probably Secondary to Colon Perforation

Metastatic Adeno Carcinoma of the Colon

X

84	January 7, 84	December 12, 83	January 7, 84
X			

Eric Fisher, M.D. c/o Maryland General Hospital

January 7, 84

January 7, 84

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Donald Harris Blackwell			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-10 1984			2b. HOUR M 10:11 a.m.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 14 46		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN 37 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2901 Druid Park Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Braille Publisher	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Linwood Blackwell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Austin		16a. SOCIAL SECURITY NO. 214 28 8153		17. INFORMANT ADDRESS 18 N. Main St. Selbyville, DE	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		18b. SOCIAL SECURITY NO. 214 28 8153		18c. CITY OR TOWN Baltimore		18d. STATE Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head (unspecified) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY est. 1-10 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was shot			
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) office		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2901 Druid Park Drive, Balto., Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Dennis F. Smyth M.D.</i>		TITLE (SPECIFY) Assistant		MEDICAL EXAMINER		DATE SIGNED 1-11-84	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/14/84		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park Berlin, Worcester		23d. LOCATION CITY OR TOWN COUNTY STATE MD	
24. FUNERAL DIRECTOR NAME Anna A. Burbage		ADDRESS 119 Williams St. Berlin		25a. DATE REC'D. BY REGISTRAR JAN 18 1984			
				25b. REGISTRAR'S SIGNATURE <i>John J. Carney</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

RECEIVED

11/11/11

11/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

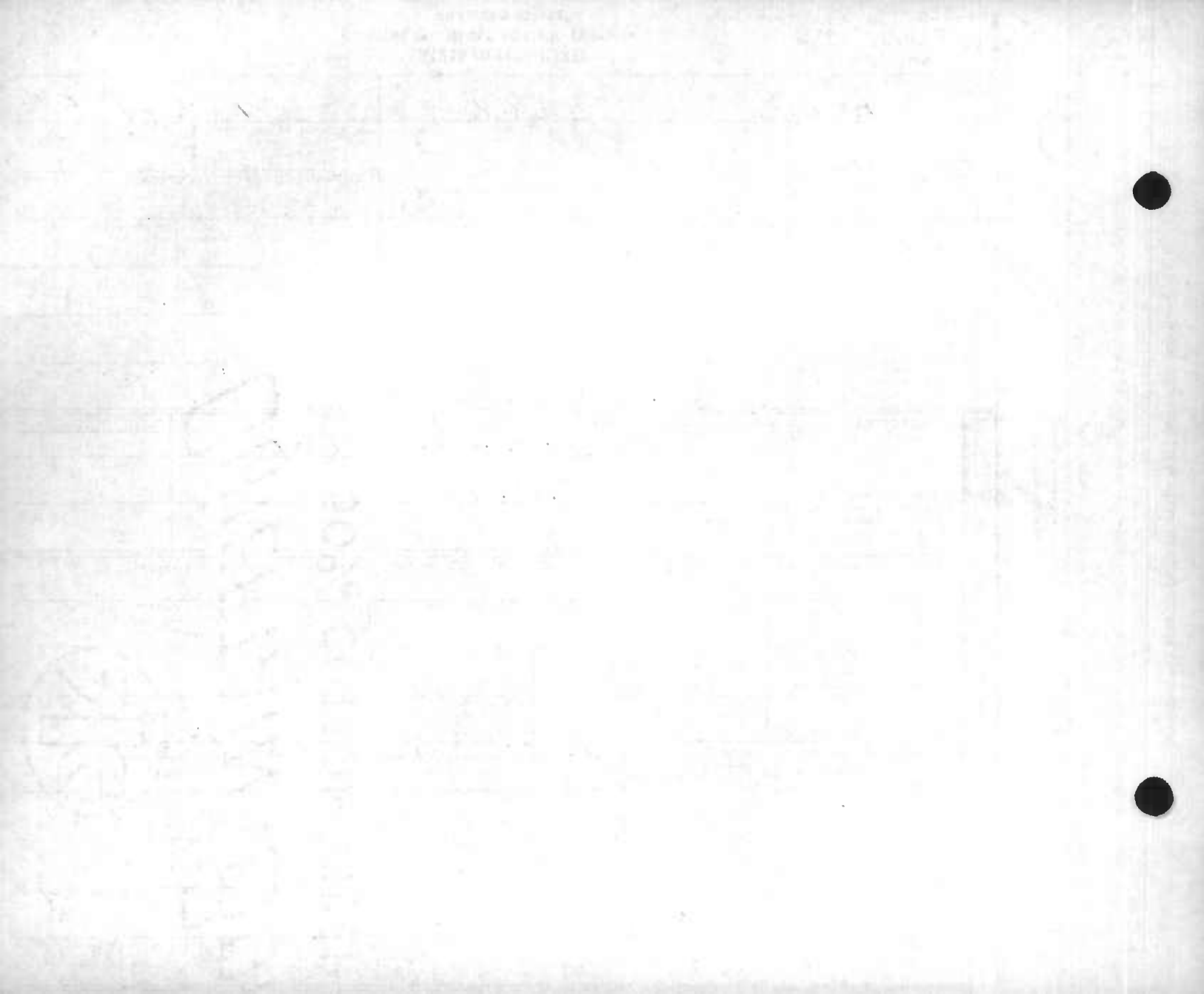
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

1- STATE REGISTRAR 2/7/84jlb

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANNIE BLAKE			2a. DATE OF DEATH MONTH 1 DAY 3 YEAR 84			2b. HOUR 5:30 PM					
3. SEX Female		4. RACE BLACK		5. DATE OF BIRTH MONTH 3 DAY 15 YEAR 91		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LINCOLN CONVALESCENT CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2224 McCulloh St. 21217		
14. FATHER'S NAME FIRST N/A MIDDLE N/A LAST N/A				15. MOTHER'S MAIDEN NAME FIRST N/A MIDDLE N/A LAST N/A							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN			16b. SOCIAL SECURITY NO. 218-38-4205		17. INFORMANT ADDRESS 1217 W. Fayette St Lincoln Convalescent Ctr.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a): Cardio-Vascular Collapse. DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 10-6- 19 71 , to 1-3- 19 84 , that (I) (we) lost saw the deceased alive on 1-2- 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A-I. BAYKALER			DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1-3-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A-I. BAYKALER			22e. ADDRESS 3459 St. Johns Lane, Ellicott City								
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 1/10/84		23c. NAME OF CEMETERY OR CREMATORY Mount Zion Cemetery Lansdowne,			23d. LOCATION CITY OR TOWN COUNTY STATE Mt Zion Md.			
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue					25a. DATE REC'D. BY REGISTRAR JAN 11 1984		25b. REGISTRAR'S SIGNATURE John J. Cahill				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 4 0 0 7 5 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES BLISCHE				2a. DATE OF DEATH MONTH DAY YEAR JANUARY 7, 1984		2b. HOUR 9:30A M	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 5/11/15		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.	
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STEEL		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN DUNDALK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS BLISCHE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SOPHIE ROOF		13e. STREET ADDRESS 21222 7047 SOLLERS PT. RD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 07 2463		17. INFORMANT ADDRESS AUDREY BLISCHE ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) LARGE & TRANSMURAL ANTERIOR MI DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from JANUARY 6, 19 84 , to JANUARY 7, 19 84 , that (1) we lost now the deceased alive on JANUARY 7, 19 84 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)							
22b. SIGNATURE John Mannisi MD DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/7/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MANNISI, MD.				22e. ADDRESS CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MD. 21231			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/10/84		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL DIRECTOR NAME J.G. CONNELLY				ADDRESS 300 MACE		25a. DATE REC'D BY REGISTRAR JAN 10 1984	
				25b. REGISTRAR'S SIGNATURE			

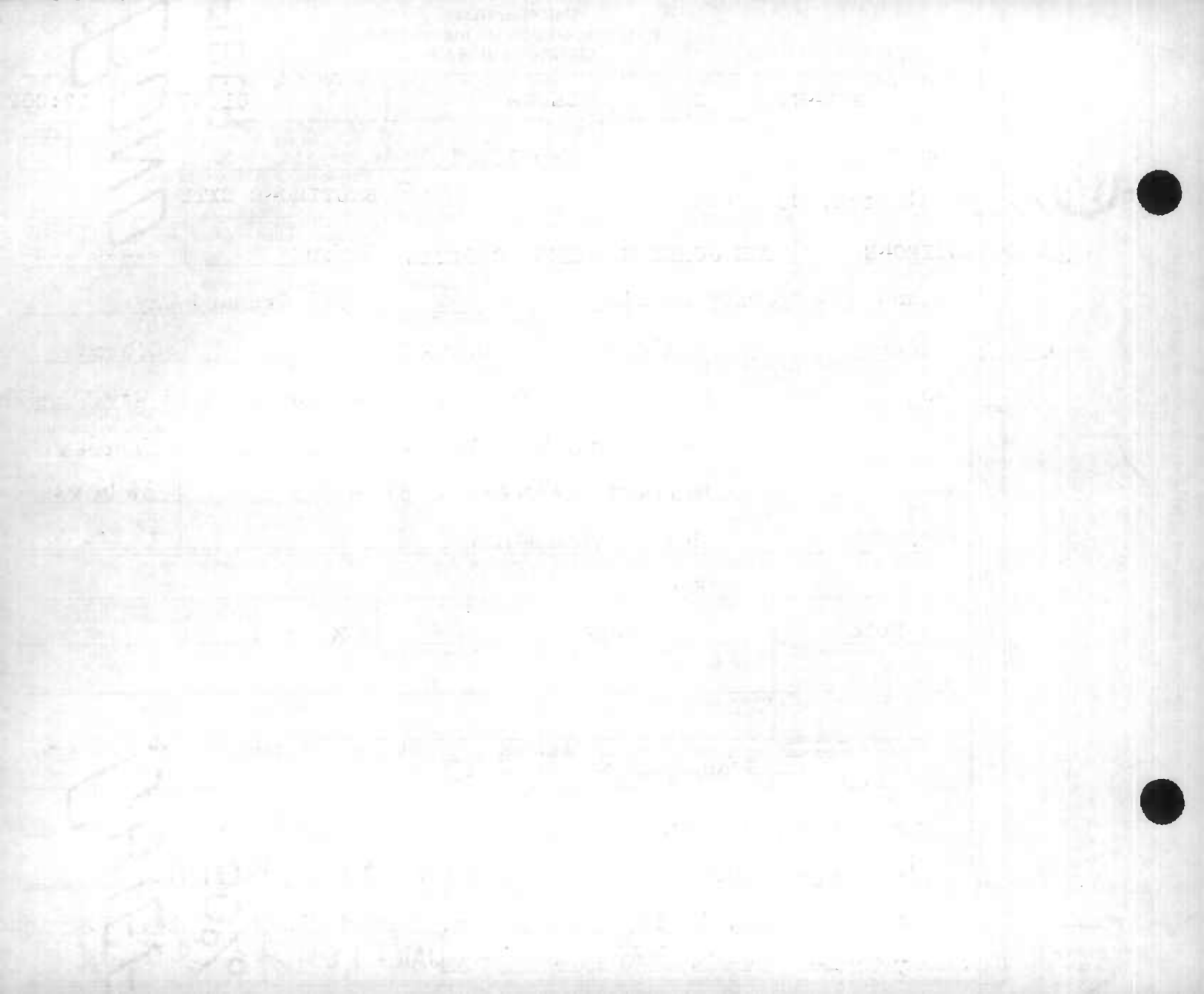
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified before the certificate is signed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) ANDREW S BLOOM					2a. DATE OF DEATH MONTH DAY YEAR 01 07 84			2b. HOUR 12:08P		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 13, 1982		6. AGE (IN YEARS LAST BIRTHDAY) 1 1/2 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Infant		12b. KIND OF BUSINESS OR INDUSTRY -----		
13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN SSpring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jeffrey Bloom					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carol Lee Gibson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS Jeffrey Bloom; 900 Orchard Way, SSpgMd						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:										
(b) INCREASED INTRACRANIAL PRESSURE										
DUE TO, OR AS A CONSEQUENCE OF										
(c) H. FLU MENINGITIS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
NONE										
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 3 JANUARY , 19 84 , to 7 JAN , 19 84 , that (I) (we) (we) last saw the deceased alive on 7 JAN , 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did (did not) view the body after death.										
22b. SIGNATURE Howard Zucker MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/7/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H ZUCKER MD		22e. ADDRESS JOHNS HOPKINS HOSPITAL								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 9, 1984		23c. NAME OF CEMETERY OR CREMATORY Judean Mem. Garden Olney, Montg., Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike		24b. DATE REC'D. BY REGISTRAR JAN 11 1984		24c. REGISTRAR'S SIGNATURE [Signature]						

BP _____



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ruth M. Blucher			2a. DATE OF DEATH MONTH 1 DAY 10 YEAR 84			2b. HOUR 10:40 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 10 DAY 24 YEAR 12		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Legal Secretary	
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST Edgar MIDDLE LAST Wright		15. MOTHER'S MAIDEN NAME FIRST Katherine MIDDLE LAST Ekas		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no (IF YES, GIVE WAR OR DATES)			
17. SOCIAL SECURITY NO. 215-05-9701		18. INFORMANT ADDRESS Ellicott City Roland Blucher 3005 Southview Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4439 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) SEPTIC SHOCK 2 DAYS (c) NECROTIC ABOVE KNEE AMPUTATION SITE 6 DAYS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HIGH BLOOD PRESSURE / RIGHT Cerebrovascular disease							
19a. DATE OF OPERATION 1-4-84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERIPHERAL VASCULAR DISEASE		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1-3-84 19 84 , to 1-10 19 84 , that (I) (we) last saw the deceased alive on 1-9 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE George Clark MD				DEGREE		22c. DATE SIGNED 1/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Clark MD				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/13/84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Baltimore Md	
24. FUNERAL DIRECTOR NAME Harry H. Witzke ADDRESS 4112 Columbia Pike, Ellicott City, Md				25a. DATE RECD. BY REGISTRAR JAN 11 1984		25b. REGISTRAR'S SIGNATURE John J. Smith	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

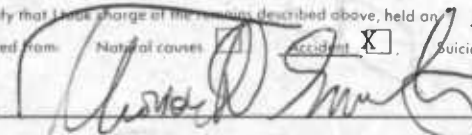
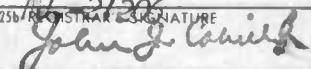
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

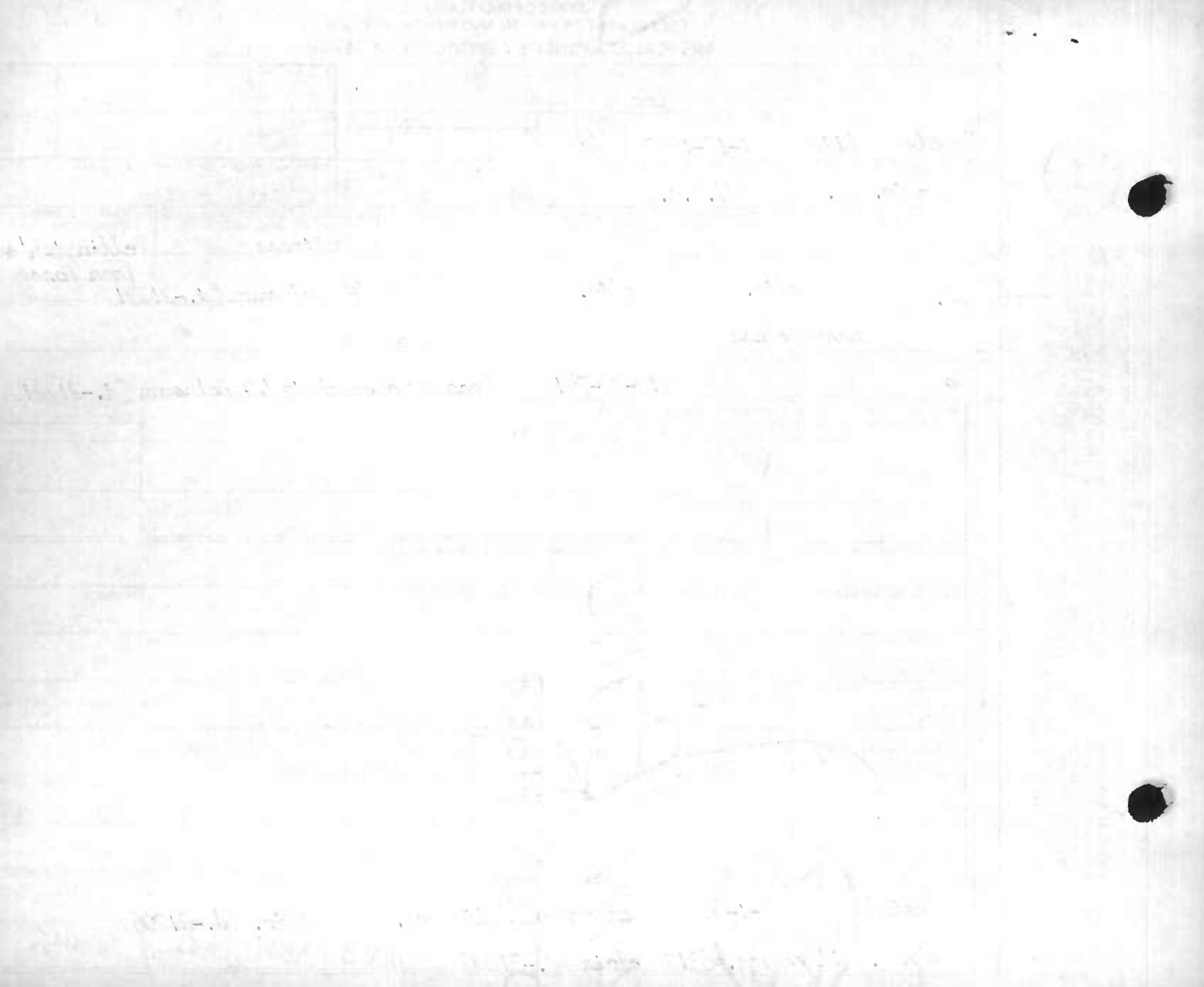
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 000762	
1. DECEASED NAME (TYPE OR PRINT) Patricia Lee Bodenschutz								2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 1 29 1984		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1-17-1935		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 29 1984	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, Md.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6600 Blk. Belair Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Pellington's Iron Horse			
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 40 Helmsman Ct. -21221			
14. FATHER'S NAME FIRST MIDDLE LAST Harry DeBross				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Rau							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 219-30-7418		17. INFORMANT ADDRESS George Bodenschutz 40 Helmsman Ct. -21221					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2 29 1 29 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Pedestrian struck by auto					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6600 Blk. Belair Rd, Baltimore Md.					
22a. I certify that I have charge of the remains described above, held and disposed of as follows: death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 1/29/84			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St.				BALTO., Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2-1-84		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. -21205			
24. FUNERAL DIRECTOR NAME John C. Miller Inc. ADDRESS 6315 Belair Rd. -21206						DATE REC'D. BY REGISTRAR JAN 31 1984		SIGNATURE 			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

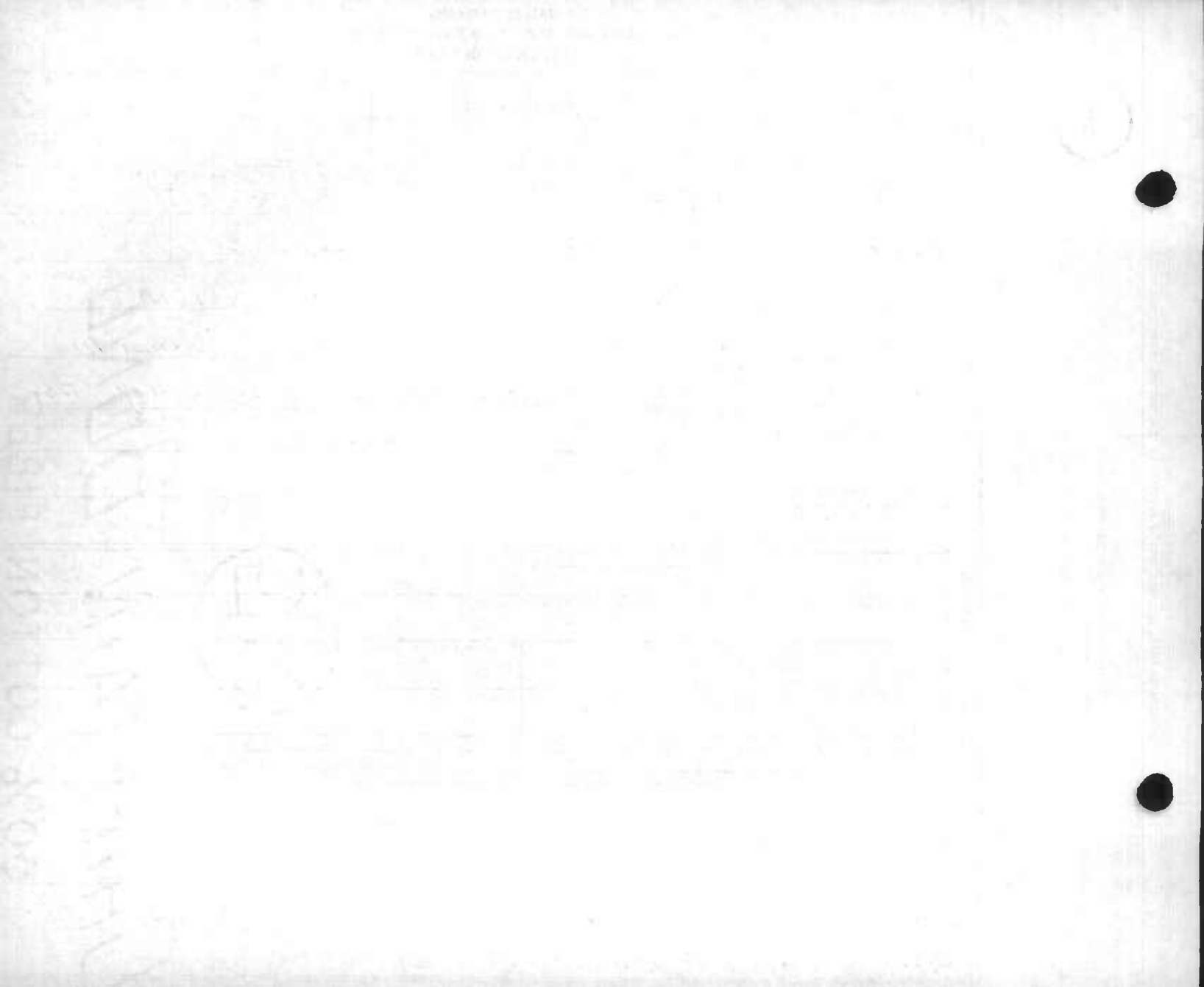
FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MADELINE BOLLACK			2a. DATE OF DEATH MONTH 1 DAY 11 YEAR 84			2b. HOUR 10:00 P.M.			
3. SEX F		4. RACE WHITE		5. DATE OF BIRTH MONTH OCT. DAY 6 YEAR 1901		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.			
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 920 S. BOULDIN ST.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.			13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST JOHN MIDDLE HANNINGAN LAST 			15. MOTHER'S MAIDEN NAME FIRST ELIZABETH MIDDLE DUNNIGAN LAST 			13e. STREET ADDRESS 920 S. BOULDIN ST. 21224			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-01-8383D		17. INFORMANT ADDRESS EARL BOLLACK 5532 LAMHAM WAY 21206				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 2030 IMMEDIATE CAUSE (a) Multiple Myeloma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 4/1 , 19 83 , to 1/11 , 19 84 , that (1) (we) lost saw the deceased alive on 1/11 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Bayani B. Elma MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/14/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BAYANI B. ELMA MD			22e. ADDRESS 3023 ECHO AVE BALTO MD 21224						
23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL			23b. DATE 1-16-84		23c. NAME OF CEMETERY OR CREMATORY OAKLAWN CEM.		23d. LOCATION CITY OR TOWN BALTO. COUNTY MD.		
24. FUNERAL DIRECTOR NAME HOFFMANN-SKARDA ADDRESS 3218 HUDSON ST.					25a. DATE REC'D. BY REGISTRAR JAN 19 1984		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84 00764

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles Edward Bolner			2a. DATE OF DEATH MONTH DAY YEAR 1-1-84			2b. HOUR 12:20 AM			
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 10-25-05		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAINTER		12b. KIND OF BUSINESS OR INDUSTRY OLAN CHEM. CO.	
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS (21225) 5116 Brookwood Rd	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN Bolner			15. MOTHER'S MAIDEN NAME MIDDLE LAST SARAH HALLER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 232-24-4062		17. INFORMANT ADDRESS Roe Bolner (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12-27, 1983, to 1-1, 1984, that (I) (we) last saw the deceased alive on 1-1, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Rhonda Richards, M.D.			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-1-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Friedman			22e. ADDRESS 3001 S. Hanover						
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 1/4/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md.		
24. FUNERAL DIRECTOR NAME Balto., Md. 21225 George J. Gonce F.H. 4001 Ritchie Hwy.					25a. DATE REC'D. BY REGISTRAR JAN 4 1984		25b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST Floyd Booker				MONTH DAY YEAR 1-21-84				M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
male		Col. 2		MONTH DAY YEAR 2-3-1924		59 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		U.S.A.				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		1904 W. SARATOGA ST				Unemployed					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS?				13b. STREET ADDRESS			
13a. STATE 13b. COUNTY Maryland Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				21223 1904 W. SARATOGA ST.			
14. FATHER'S NAME FIRST MIDDLE LAST William Booker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Booker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No				22520-2261		Mr. CARROLL BENNS		2504 W. LAFAYETTE AVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) Coronary attack										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R. M. S. S. B. U. N. O. M.								DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/24/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS Baltimore Harbor					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial				1-26-84		Arbutus Mem. Park		Baltimore Co. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Joseph L. Russ 2222 W. North Ave.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
						JAN 25 1984		John J. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) George Louis Booker				2a. DATE OF DEATH MONTH DAY YEAR 1-15-84			
3. SEX male				2b. HOUR 3:23 PM			
4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12-12-06		6. AGE (IN YEARS LAST BIRTHDAY) 77		8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		10. CITY OR TOWN OF DEATH Baltimore	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Machinist		12b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.		13a. STREET ADDRESS 21225 4134 Hague Ave.	
13a. STATE MD		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Booker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minerva Grund		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 705-05-3478	
17. INFORMANT Mrs. Gretchen L. Booker		ADDRESS Same as #13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1629 Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) metastatic Bronchogenic Squamous Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) ---		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ---							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. DATE SIGNED 1-15-84	
22b. SIGNATURE Rhonda Richards, M.D.							
22c. DEGREE ---							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Drs Feldman / Mundra							
22e. ADDRESS 3001 S. Hanover							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/19/1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., A. A. Co., Md.	
24. FUNERAL DIRECTOR NAME McCutty Funeral Homes				25a. DATE REC'D. BY REGISTRAR JAN 17 1984		25b. REGISTRAR'S SIGNATURE John J. Connel	

STANDARD 10-74-100-7

... ..

75%

(1) 100%

20% COTTON

CHIEF



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
ROBERT L. BOOKER						01/13/84			3:53pm		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		Black		9 5 14		69 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia			U.S.A.						BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
BALTIMORE			THE JOHNS HOPKINS HOSPITAL								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
Maryland					Baltimore				603 Winston Avenue 21212		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Joseph A. Booker			Felina Fowlkes								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
NO			213-09-3921			Sallie M. Booker 603 Winston Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>										0	
1519 DUE TO, OR AS A CONSEQUENCE OF (b) <u>renal failure</u>										5 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>stomach carcinoma</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a- <u>diffuse intravascular coagulation,</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
1/11/84			stomach cancer								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/13 3:53 PM 19 84</u> to <u>1/13 19 84</u> , that (I) (we) lost saw the deceased alive on <u>1/13 3:53 PM 19 84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Peter C. Belitros MD</u>			DEGREE			22c. DATE SIGNED <u>1/13/84</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
Peter C. Belitros			601 N. Wolfe St. Baltimore, Md. 21205								
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL			1/18/84		Baltimore Cemetery			Baltimore Md.			
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
William C March F/H Inc. 1101 E. North Ave.						JAN 17 1984		<u>John J. Connel</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. It may be retained by the hospital or attending physician for 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEMORANDUM

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Ruben Booker			1 9 84			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male	Black	11 6 1898	85 86 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia	U.S.		Baltimore City MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	449 Roundview Road		Farmer					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			449 Roundview Road 21225		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
		Nancy Booker						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
		217-01-2337		Viola Booker 449 Roundview Road				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4280 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE Deputy Chief Medical Examiner ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 1/13/84						
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
Thomas D. Smith, M.D.		111 Penn ST. Balto., MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		1-14-84		Mt. Auburn Cemetery		Baltimore Maryland		
24. FUNERAL DIRECTOR Brown-Thompson F.H. 1913 W. Baltimore St.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
				JAN 24 1984		[Signature]		

BP



[Faint, illegible handwritten signature or text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) William H. Booker Sr.						2a. DATE OF DEATH MONTH DAY YEAR January 22, 1984		2b. HOUR 5:00 P.M.	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 6 16		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			13e. STREET ADDRESS 5810 Edgepark Road 21215			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WWII		17. INFORMANT ADDRESS Thelma Powell 1532 Stonewood Road				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 4360 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ Gangrene Toes, Cerebrovascular Accident									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (he/she/this hospital) attended the deceased from December 20, 1983 , to January 22, 1984 , that (X) (we) last saw the deceased alive on January 22, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (do not) view the body after death.									
22b. SIGNATURE Bruce Shames MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/22/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce Shames, M.D.				22e. ADDRESS C/O Maryland General Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/26/84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills, MD.			
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc, 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR JAN 24 1984		25b. REGISTRAR'S SIGNATURE John J. Coniff			

RECEIVED
JAN 11 1961

A

x

15/10/61

CHERRY

20% COLIC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					2b. HOUR	
1. DECEASED NAME [TYPE OR PRINT] John E Bopp, Jr.					MONTH DAY YEAR 1 25 89					10:50 P.M.	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1 13 23		6. AGE [IN YEARS (LAST BIRTHDAY)] 61 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) Balt. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.					
10. CITY OR TOWN OF DEATH Baltimore Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Oper.			12b. KIND OF BUSINESS OR INDUSTRY Social Sec.		
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7620 Perring Terrace 21234			
14. FATHER'S NAME FIRST MIDDLE LAST John E Bopp					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Anna Koppelman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-24-1543		17. INFORMANT ADDRESS Virginia Bopp 7620 Perring Terrace (21234)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5131 Cardiac Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Bacterial Sepsis										48 hrs	
DUE TO, OR AS A CONSEQUENCE OF (c) Mediastinal Abscess										Unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Osteogenesis Imperfecta											
19a. DATE OF OPERATION Dec 2nd, 83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary Artery Disease				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 22 S Greene St. Baltimore Maryland							
22a. I certify that (I) (this hospital) attended the deceased from 12/1 , 19 83 , to 1/25 , 19 84 , that (I) (we) lost saw the deceased alive on 1/25 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Protogoras Cutchis MD					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 1/26/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Protogoras Cutchis					22e. ADDRESS 22 S Greene St.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-30-84		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home ADDRESS Balto., Md. 21201											

[Faint handwritten text at the bottom of the page]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FLORENCE M. BORDEAUX		01 24 84		240P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		
Female	White	9-16-32	51 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. BALTIMORE CITY OR COUNTY OF DEATH			
Penna	U.S.A.	Baltimore City MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Balto. Md.	Church Hospital	C.S.P. Telephone			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Md.	Balto.	Balto.	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1801 Willow Spring Road-21222	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
Norman Beers		Hilda Stevens		21221	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		17. INFORMANT		ADDRESS	
No		Edwin L. Bordeaux		1801 Willow Spring Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Adenocarcinoma Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that this hospital attended the deceased from Jan 17, 1984, to Jan 24, 1984, that I saw the deceased alive on Jan 24, 1984, and that in my opinion death occurred on the date and hour and from the causes stated above. (If not, did (do not) view the body after death.)					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Vikas Saini				1-24-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
VIKAS SAINI		2524 GUILFORD 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		1-28-84		Gardens of Faith	
24. FUNERAL DIRECTOR		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR	
John C. Miller Inc. - 6415 Belair Rd. - 21206		Balto. Md.		JAN 25 1984	
25. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE			
John C. Miller		John C. Miller			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1935 18 15 17 1935 18 15 17

1935 18 15 17 1935 18 15 17

1935 18 15 17 1935 18 15 17

1935 18 15 17 1935 18 15 17

1935 18 15 17 1935 18 15 17

1935 18 15 17 1935 18 15 17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8400772			
1. DECEASED NAME (TYPE OR PRINT) STANLEY BOSTIAN				2a. DATE OF DEATH MONTH DAY YEAR 1 5 84			
3. SEX M		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 5 30 12		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Maryland Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 2100		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
16b. SOCIAL SECURITY NO. 216-03-1705A		17. INFORMANT ADDRESS GRANADA NURSING HOME-LIBERT HGTS. AV					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest 1629 DUE TO, OR AS A CONSEQUENCE OF (b) small cell CA lung - SVC syndrome DUE TO, OR AS A CONSEQUENCE OF (c) Gm @ pneumonia							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/5 19 84 , to 1/5 19 84 , that (I) (we) lost saw the deceased alive on 1/5 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. METZ		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1.5.84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. METZ		22e. ADDRESS Univ. Maryland Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/10/84		23c. NAME OF CEMETERY OR CREMATORY BEAVER DAM CEM		23d. LOCATION CITY OR TOWN COUNTY STATE UNION BRIDGE MD.	
24. FUNERAL DIRECTOR LEROY O. DYETT & SON F.H., Inc.				25a. DATE REC'D. BY REGISTRAR JAN 10 1984			
25b. REGISTRAR'S SIGNATURE John J. ...							

RECEIVED

(1)

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) DAVID A. BOUDJEDA		2a. DATE OF DEATH MONTH <u>1</u> DAY <u>23</u> YEAR <u>84</u>		2b. HOUR <u>3:45pm</u>
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH <u>Dec.</u> DAY <u>30</u> YEAR <u>1925</u>	6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	7. IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Paris	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer	12b. KIND OF BUSINESS OR INDUSTRY Board of Ed.	
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Towson	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 221 Linden Ave. - 21204
14. FATHER'S NAME FIRST Charles MIDDLE Boudjeda LAST Boudjeda		15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE Unknown LAST Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 215-44-1600	17. INFORMANT ADDRESS Albert F. Boudjeda - Same as #13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) Hepatic Encephalopathy DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic mets from Ca Colon DUE TO, OR AS A CONSEQUENCE OF (c) 				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1/13/84</u> 19 <u> </u> to <u>1/23/84</u> 19 <u> </u> , that (I) (we) lost saw the deceased alive on <u>1/23/84</u> 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Jyotin Parikh		DEGREE MD		22c. DATE SIGNED 1/23/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JYOTIN PARIKH		22e. ADDRESS Good Samaritan Hospital		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-27-84	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley	23d. LOCATION CITY OR TOWN COUNTY STATE Timonium, Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		ADDRESS 1050 York Rd.	25a. DATE REC'D. BY REGISTRAR JAN 27 1984	25b. REGISTRAR'S SIGNATURE John J. Carick

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked children (18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

Item# 16a 1/20/84 mtb F#587

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 4 0 0 7 7 4

1. DECEASED NAME (TYPE OR PRINT) STEPHEN BOYCHECK			2a. DATE OF DEATH MONTH DAY YEAR 01-04-84			2b. HOUR 755 A M				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN. 6, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 54		7. YRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECH.		12b. KIND OF BUSINESS OR INDUSTRY GLASS Co.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1329 JAMES ST. 21223				
14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL BOYCHECK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA KOSTINGO						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OPERATES) YES WWII		16b. SOCIAL SECURITY NO. 197/24 2800		17. INFORMANT ADDRESS DOLORES MENCE MAIN ST. MAIZEVILLE PA.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTIC SHOCK 5860 DUE TO, OR AS A CONSEQUENCE OF (b) DISSEMINATED INTRAVASCULAR COAGULATION DUE TO, OR AS A CONSEQUENCE OF (c) RENAL FAILURE									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from JAN. 1 , 19 84 , to JAN. 4 , 19 84 , that (I) (we) last saw the deceased alive on JAN 4 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE William L. Yap				DEGREE MD				22c. DATE SIGNED Jan 4, 1984		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM L. YAP MD				22e. ADDRESS ST. AGNES HOSPITAL, BALTIMORE MD						
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 1-6-84		23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEM			23d. LOCATION CITY OR TOWN COUNTY STATE FRACKVILLE PA.		
24. FUNERAL DIRECTOR NAME CAPITAL FUN. SER.				ADDRESS FALLS CHURCH VA.		25a. DATE REC'D. BY REGISTRAR JAN 5 1984		25b. REGISTRAR'S SIGNATURE Joan J. Connel		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be directed for use as the burial-transit permit. Then please remove carbon copies of page 1 and 2 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as fatal, 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1- STATE REGISTRAR		DEPART. CERTIFICATE OF DEATH		GIENE 8 4 0 0 / 7 5		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
Dominic		Boykins		01/24/84		12:45P	
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
MALE	BLACK	9 3 83		YRS 4			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
BALTO., MD.	USA			Baltimore City MD.			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Baltimore	The Johns Hopkins Hospital						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a CITY OR TOWN		13b STREET ADDRESS / ZIP CODE			
13a STATE		13b COUNTY		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Md.		BALTO.		1514 EUTAW PL.		21217	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
SAMMIE L. BOYKINS		DARLENE					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
NO				DARLENE BOYKINS 1514 EUTAW PL. 21217			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3485 IMMEDIATE CAUSE (a) cerebral ischemia							
DUE TO, OR AS A CONSEQUENCE OF (b) cerebral edema							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO, OR AS A CONSEQUENCE OF (c) anoxia							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from JAN 11/84 84 to 1245PM 1/24 19 84, that (I) (we) last saw the deceased alive on 1245 PM 1-24 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.							
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED	
D JACKSON MD						1-24-84	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS					
D JACKSON MD		JOHNS HOPKINS HOSPITAL PICK.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		1/27/84		KING MEM. PK.		BALTO., MD.	
24 FUNERAL DIRECTOR NAME				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
LEROY O. DYETT 4600 LIBERTY HGTS. AVE.				JAN 30 1984		R. J. Conner	

1215

1215

1215

X

1215

1215

BRASHEARS, LOUISE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) LOUISE JONES BRASHEARS			2a. DATE OF DEATH MONTH DAY YEAR 1/6/84		2b. HOUR 1:35 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 4, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3501 St. Paul St., 21218
14. FATHER'S NAME FIRST MIDDLE LAST ? Jones		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Welch			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Andrew D. Brashears, Jr., MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>aspiration with probable pneumonitis</u> 5355 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>gastroenteritis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>stroke ERROR</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>stroke</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan 6 19 84, to Jan 6 19 84, that (I) (we) last saw the deceased alive on Jan 6 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE B E Brandt MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/6/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. E. BRANDT		22e. ADDRESS UNION MEMORIAL HOSPITAL Union Memorial			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/9/84	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212			25a. DATE REC'D. BY REGISTRAR JAN 9 1984		25b. REGISTRAR'S SIGNATURE John J. Smith

21215 100% C3H8 100% C3H8 100% C3H8

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 / 7 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HESTER V. BRAZIER		2a. DATE OF DEATH MONTH DAY YEAR 1 2 84		2b. HOUR 6:15am	
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5-29-1888		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 95 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bugle Laundry		12b. KIND OF BUSINESS OR INDUSTRY Retired
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Jordan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Gray			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-30-7949		17. INFORMANT ADDRESS Mrs. Irene L. Masek - 4262 Nicholas Ave. 21206	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia 4860 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Constrictive Heart Failure					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/1/84 , 19 84 , to 1/2 , 19 84 , that (I) (we) lost saw the deceased alive on 1/1 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert Vissing		DEGREE MO		22c. DATE SIGNED 1/2/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT VISSING		22e. ADDRESS 201 E UNIVERSITY PKWY			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-4-84		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		24. FUNERAL DIRECTOR NAME ADDRESS John C. Miller Inc-6415 Belair Rd.-21206			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John J. Connel			

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "incomplete" and any injury, or other traumatic event, the medical examiner must be notified.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 / 7 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM Delvon BRIGHTFUL			2a. DATE OF DEATH MONTH DAY YEAR 1 18 84			2b. HOUR 2 A M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4 20 80		6. AGE (IN YEARS LAST BIRTHDAY) 3 1/2 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2904 Ulman Ave				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE MD		13b. COUNTY Balto		13c. STREET ADDRESS 2904 Ulman Ave	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM BRIGHTFUL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHARLENE MYERS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, HO OR UNKNOWN) 0		16b. SOCIAL SECURITY NO. 0	
17. INFORMANT Charlene Myers, 2904 Ulman Ave. 21215		18. ADDRESS		19. ADDRESS		20. ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiorespiratory arrest 1940 DUE TO, OR AS A CONSEQUENCE OF (b) Disseminated Neuroblastoma DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/18/84 11/10/83	
--	--	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/10/83, 19 83, to 1/18, 19 84, that (II) (we) last saw the deceased alive on 1/16, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Blanca L. Ibor MD		22c. DATE SIGNED 1/18/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BLANCA L. IBOR MD		22e. ADDRESS 22 S. Greene st. Balto MD 21211	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/20/84		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Law Funeral Home 4611 Park Heights Ave.				25a. DATE REC'D. BY REGISTRAR JAN 24 1984			
25b. REGISTRAR'S SIGNATURE John J. Carver							

1

WILLIAM

BRIGHTEN

1 18 84 2A

Male

Black

A 40 80

3 1/2

MD

USA

Baltimore

3204 Union Ave

MD

Balto

3204 Union Ave

WILLIAM

BRIGHTEN CHARENE

MARR

cardiographic quest

Discontinued Newbold stone 11/10/83

11/18/84

0

1116

84

1116183

83

1118

84 0

Blanca 1 Ipa MD

✓

11/18/84

BLANCA 1 Ipa MD

55 2 0000 27 Ballo H021511

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84 00179

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CELESTINE M. BRISCOE			2a. DATE OF DEATH MONTH DAY YEAR JAN. 6, 1984		2b. HOUR PM 12:30				
1. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 11 17 07		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 76 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.			
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS) 3016 MONDAWMIN AVE.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3016 MONDAWMIN AVE.	
14. FATHER'S NAME FIRST MIDDLE LAST JORDAN T. GWALTNEY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE WEBB						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS DONALD BRISCOE 3002 MONDAWMIN AVE.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) Cardio pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ischemic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Heart Failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 4 8 19 83 to 1-6 19 84 , that (we) lost saw the deceased alive on 1-6 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (2) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edward Stan				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-9-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward Sherman				22e. ADDRESS 8726 Liberty Rd. W. Md.					
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 1/10/84		23c. NAME OF CEMETERY OR CREMATORY BALTO. NAT. CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD.			
24. FUNERAL DIRECTOR NAME ADDRESS LEROY O. DYETT 4600 LIBERTY HGTS. AVE.				25a. DATE REC'D. BY REGISTRAR JAN 10 1984		25b. REGISTRAR'S SIGNATURE Sharon E. Connel			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Philander Bowen Briscoe Sr.			2a. DATE OF DEATH MONTH DAY YEAR 1-28 84			2b. HOUR 9:50 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 23 1891		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3811 Canterbury Road, 21218				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney	
12b. KIND OF BUSINESS OR INDUSTRY Self-employed		13a. STREET ADDRESS / ZIP CODE 3811 Canterbury Road, 21218		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME (TYPE OR PRINT) John Parran Briscoe		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) Kate McPherson Bowen		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W.W.I 217/38/5933	
17. INFORMANT Wife (Luisa L. Briscoe)		18. DATE OF DEATH 1-28-84		19. TIME OF DEATH 9:50 AM		20. PLACE OF DEATH Home	

II CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest

4292

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) C. V. A

DUE TO, OR AS A CONSEQUENCE OF

(c) A. S. C. U. D

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

0

6 days

10 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 0

MEDICAL CERTIFICATION

19a. DATE OF OPERATION 0		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) the hospital attended the deceased from 1-28-84, to 1-28-84, that (I) was lost saw the deceased alive on 1-28-84, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was did not view the body after death.							
22b. SIGNATURE Dr. C. W. Montague MD				DEGREE MD		22c. DATE SIGNED 1-28-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MONTAGUE A.				22e. ADDRESS 5820 York Rd. Balto Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/1/84		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Epis.		23d. LOCATION CITY OR TOWN COUNTY STATE Calvert Co., MD	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212				25a. DATE REC'D. BY REGISTRAR JAN 30 1984			
				25b. REGISTRAR'S SIGNATURE John L. Cahill			

1020

18

2

1

2

1

2

1

2

1

Continued

W. W. I. 211 V. 111

Printed by the
F. J. Smith & Co.
New York, N. Y.
1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal inquest must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST	MIDDLE	LAST		MONTH	DAY	YEAR	MONTH	DAY	YEAR	HOURS	MIN.
ARCHIE LEE BROOKS				1 21 84				343 PM			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
male		Black		5 5 32				51 YRS.		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
mexico		USA						City MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Baltimore				University				disabled.			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD				BALT		BALT		YES <input type="checkbox"/> NO <input type="checkbox"/>		4015 Woodmere Ave	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Hunter				Brooks							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
YES				100-22-5421		MARY JACKSON 4015 WOODMERE AVE.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:											
4321 IMMEDIATE CAUSE (a) Cardiopulmonary arrest											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Subdural Hematoma											24 HRS
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Chronic Renal Failure											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
1/20/84				Subdural Hematoma				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/20/84 to 1/21/84, that (I) (we) last saw the deceased alive on 1/21/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Louis Solomon				MD				1/21/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Louis Solomon				University Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION	
BURIAL				1/26/84		KING MEM. PK.				BALTO., MD.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR							
LEROY O. DYETT 4600 LIBERTY HGTS. AVE.				JAN 24 1984							
				25b. REGISTRAR'S SIGNATURE							
				John L. Smith							

BP

1

WESTERN
NRA

WESTERN
NRA

WESTERN
NRA

WESTERN
NRA

WESTERN
NRA

WESTERN
NRA

WESTERN
NRA

WESTERN
NRA

WESTERN
NRA

WESTERN
NRA

WESTERN
NRA

WESTERN
NRA

WESTERN
NRA

WESTERN
NRA

WESTERN
NRA

WESTERN
NRA

WESTERN
NRA

WESTERN
NRA

Item #6, G-591, 5/9/84, by F.H., STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 4 0 0 7 8 2

1. FOR
 STATE
 REGISTRAR

Gbj.

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES R. BROOKS			2a. DATE OF DEATH MONTH 1 DAY 12 YEAR 84		2b. HOUR 8:00^{AM}
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH 2 DAY 5 YEAR 04	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. 79 MONTHS 00 DAYS 00 HOURS 00 MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) FREDERICK, MD.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.		
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 3307 SPRINGDALE AVE.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD.		13b. COUNTY BALTO.	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS 3307 SPRINGDALE AVE.
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 214-16-0242		17. INFORMANT JEROME ELLIS ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5789 Duodenal ulcer treated DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent G.I. bleeding DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic myocardial disease & hypertrophy					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) see the body after death.					
22b. SIGNATURE ERIC L. WHITE		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERIC L. WHITE		22e. ADDRESS 524 OLD TOWN MALL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/16/84		23c. NAME OF CEMETERY OR CREMATORY JOHNSVILLE CH. CEM.	
23d. LOCATION CITY OR TOWN COUNTY STATE FIDERSBURG, MD.		23e. DATE REC'D. BY REGISTRAR JAN 17 1984		23f. REGISTRAR'S SIGNATURE John J. Connel	
24. FUNERAL DIRECTOR LEREOY O. DYETT 4600 LIBERTY HGTS. AVE.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and registered in the funeral director's office, page 3 should be detached for use as the burial-transit permit. Then please remove the pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

THE UNIVERSITY OF CHICAGO
LIBRARY



108001



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and the medical examiner's report must be attached.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
RICHARD W. BROOKS			JANUARY 29, 1984			12:30P		
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR		
Male	White	3 MONTH 8 DAY 1935	48 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	USA		BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	THE JOHNS HOPKINS HOSPITAL		Account Executive			Trucking		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		
Md.	Balto	Hampstead	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			17909 Marshall Mill Road 21074		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. ADDRESS		
Thomas Brooks			Jessie Harris			Mrs. Shirley A. Brooks, Hampstead, Md.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
no			215-32-7273			Mrs. Shirley A. Brooks, Hampstead, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Failure</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Small Cell Carcinoma of the Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> , 19 <u>84</u> , to <u>1/29</u> , 19 <u>84</u> , that (I) (we) last saw the deceased on <u>1/29</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.			22b. SIGNATURE <u>[Signature]</u>			22c. DATE SIGNED <u>1/29/84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PARNES</u>			22e. ADDRESS <u>5. N. H. Baltimore, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			2-1-84		Immanuel Cemetery		Manchester Carroll Md.	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Eline Funeral Home, Hampstead, Md. 21074			JAN 30 1984			<u>[Signature]</u>		

BP _____

3

Small 2nd Generation / 1st Generation

James C. [Signature]

2nd Generation

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 7 8 4

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anna D. Brown			2a. DATE OF DEATH MONTH DAY YEAR 01 07 84			2b. HOUR 1:15 PM			
3. SEX Female		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 09 19 57		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEATON Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic worker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN XXXXXXXXXXXX		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3412 Bateman Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas H. Derricks				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Edwards					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 5 79-40-7014		17. INFORMANT ADDRESS Mrs. Louise Turks-cousin-3412 Bateman Avenue, Baltimore, Maryland			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) unknown. 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ASCVD, cardiomyopathy, Hx atrial fib, renal failure, hypothyroid										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from December 17, 1983 to Jan 7, 1984 , that (I) (we) last saw the deceased alive on Jan 7, 1984 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.										
22b. SIGNATURE Wendy Kloes					DEGREE MD		22c. DATE SIGNED 1/8/84		22d. ADDRESS FHC - U of Md Hosp 225 Greenest	
23a. BURIAL, CREMATION, REMOVAL Burial					23b. DATE Jan 14, 1984		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery Suitland, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR Stewart Funeral Home 4001 Benning Rd., N.E.					25a. DATE REG'D. BY REGISTRAR JAN 17 1984					25b. REGISTRAR'S SIGNATURE John J. Canfield

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

CHIEF OF

20% COLICM

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR		MIN.	
CLARENCE				BROWN				1		24		84							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.									
MALE		BLACK		4 17 34		49 YRS.		MONTHS		DAYS		HOURS		MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
SOUTH CAROLINA		US				CITY													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
BALTIMORE		900 LENTON AVE. 21212																	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
MARYLAND						BALTIMORE				900 LENTON AVE. 21212									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
HARRY		QUEENIE																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
YES		217-28-3922		JUNE BROWN		900 LENTON AVE. 21212													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Metastatic Adenocarcinoma of lungs		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
1629		DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)																	
		DUE TO, OR AS A CONSEQUENCE OF																	
		(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		N/A																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
N/A		N/A		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
		P.M. 19		N/A															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
		N/A		N/A															
22a. I certify that (I) (this hospital) attended the deceased from Dec. 19 83, to January 19 84, that (I) (we) lost the deceased alive on January 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED													
		ADEL S. EL-HEINAWY		M.D.		1-26-84													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
ADEL S. EL-HEINAWY		UMCC																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
BURIAL		1-28-84		SPRING HILL GARDENS		SALISBURY MARYLAND													
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
E.L. PHILLIPS		1721 N. MONROE ST.		JAN 30 1984		John J. Carver													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

MEDICAL CERTIFICATION

BP.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, mark any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) CLARENCE PAUL BROWN			2a. DATE OF DEATH MONTH DAY YEAR 1 15 84		2b. HOUR 6:30p M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 22, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE ADDRESS) VA MEDICAL CENTER BALTO., MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supt. Balto.	12b. KIND OF BUSINESS OR INDUSTRY City		
13a. STATE Maryland	13b. COUNTY BALTIMORE	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS, ZIP CODE 1295 William St. Balto. Md. 21230		
14. FATHER'S NAME FIRST Miltos MIDDLE Lee LAST Brown		15. MOTHER'S MAIDEN NAME FIRST Gladys MIDDLE K. LAST Brown Pinen				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YOU GIVE WAR OR DATES) Korean 220-20-3762		17. INFORMANT ADDRESS Mrs. Irene Betty Brown, Same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1991 IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) metastatic squamous cell cancer DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 7, 1983, to JANUARY 15, 1984, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on JANUARY 15, 1984, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.						
22b. SIGNATURE Mark E. Richards MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/15/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark E. Richards MD		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan. 19, 1984	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME McGully Funeral Home, 130 E. Fort Ave. Balto. Md.		ADDRESS 21230		25a. DATE REC'D. BY REGISTRAR JAN 17 1984		25b. REGISTRAR'S SIGNATURE John J. Connelley

BP

11/11/11

11/11/11



11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

X

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner is to be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 7 8 7

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DA'SY B. Brown			2a. DATE OF DEATH MONTH DAY YEAR 1 - 23 - 84			2b. HOUR 12:20p M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 - 5 11		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 5 22	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City, Bto. MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hosp. of Md				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Bto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 325 Menechen Street. 21217	
14. FATHER'S NAME FIRST MIDDLE LAST N/A				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST N/A					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Apt. 5C Marian R. Brown 1701 Madison Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis 2° to Deenbitus ulcer. 0389 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) diabetes mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 11 - 23 1984, to 1 - 23 1984, that (I) (we) lost saw the deceased alive on 1 - 23 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Matthew				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1 - 23 - 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Mathew				22e. ADDRESS Lutheran Hospital - 730 N. E. Center Street Baltimore					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/27/84		23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue				25a. DATE REC'D BY REGISTRAR JAN 24 1984		25b. REGISTRAR'S SIGNATURE John J. Casper			

BP

(1)

RECEIVED

20% COTTON FIB

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 4 0 0 7 8 8			
Item 13 at tue phone 1-23-84 FOR STATE REGISTRAR 21201							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Errol Lorenzo BROWN II BABY BOY				2a. DATE OF DEATH MONTH DAY YEAR JANUARY 7, 1984		2b. HOUR 11:10A	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR JAN 7 1984		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 12	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. CITY OR TOWN Severn		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 8283 Deerfield Ct 21144	
14. FATHER'S NAME FIRST MIDDLE LAST Errol Lorenzo Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angela Williams		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO.		17. INFORMANT Errol L. Brown		ADDRESS Severn, Md		17b. ADDRESS 8283 Deerfield Ct	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 7597 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Severe multiple congenital anomalies DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan 7 1984 to Jan 7 1984 , that (I) (we) lost saw the deceased alive on Jan 7 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. Gary Karlowicz				DEGREE MD		22c. DATE SIGNED 1/7/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY KARLOWICZ				22e. ADDRESS JOHNS HOPKINS HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN 11, 1984		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS AA MD	
24. FUNERAL DIRECTOR NAME C.E. Hicks				24b. ADDRESS 1922 Forest Dr		25a. DATE RECD. BY REGISTRAR JAN 17 1984	
				25b. REGISTRAR'S SIGNATURE John J. Carver			

BP

AMERICAN



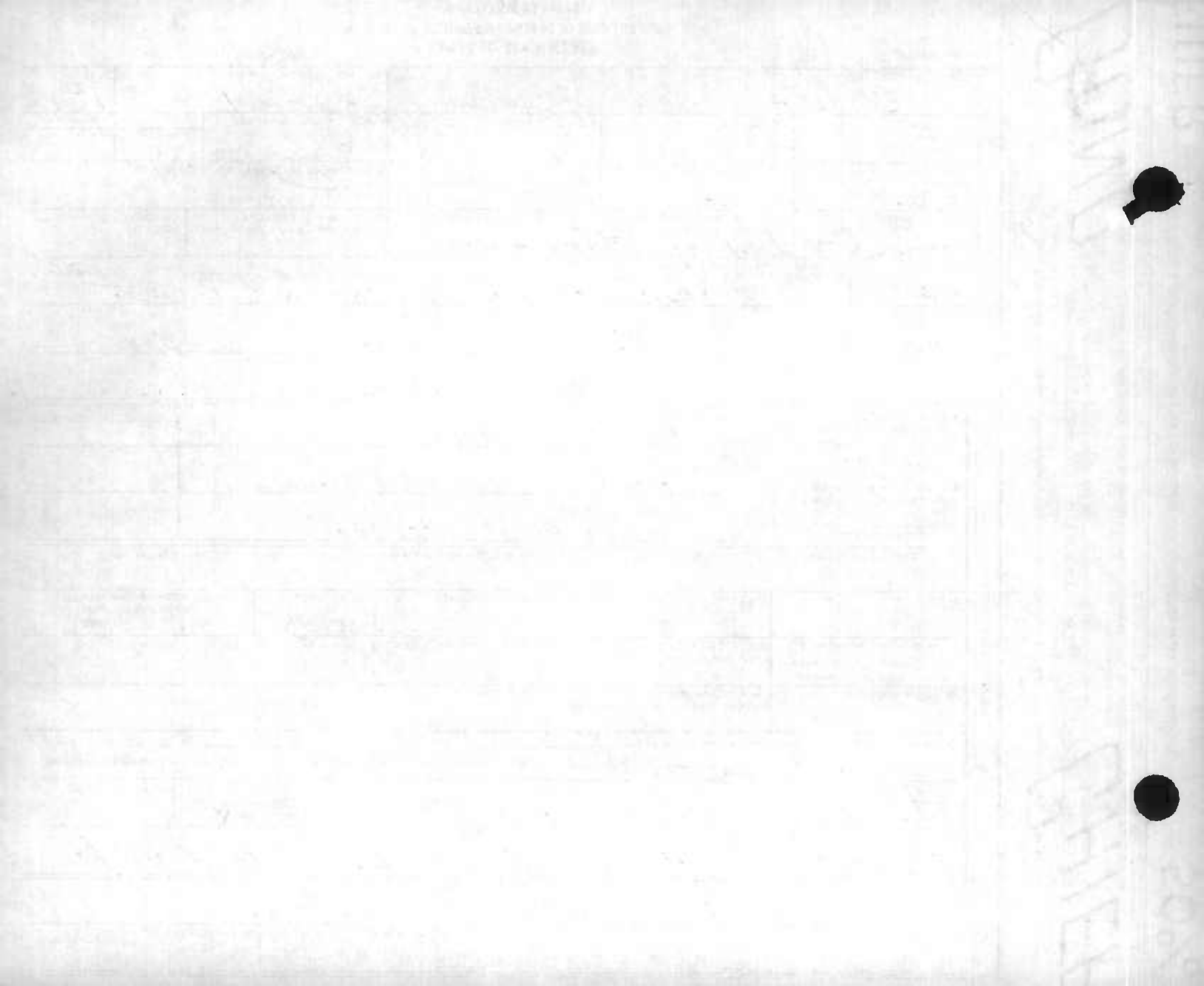
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 84 00789						
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ESTELLA LANE BROWN					1-3-84					120 PM	
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 1 13 15		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS			IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV of MARYLAND				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 305 N Calhoun ST 21223			
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD LANE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCINDA BRISCOE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 220-38-6594		17. INFORMANT ADDRESS James Watkins, Jr. 305 N. Calhoun St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE 2030 DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) MULTIPLE MYELOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Thomas L Pallone MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS L PALLONE				22e. ADDRESS Univ of Maryland Hosp.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/7/84		23c. NAME OF CEMETERY OR CREMATOR Arbutus Mem. Pk.			23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md.		
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue						25a. DATE REC'D. BY REGISTRAR JAN 4 1984			25b. REGISTRAR'S SIGNATURE John J. [Signature]		



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84 000790

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George F. BROWN, SR.			2a. DATE OF DEATH MONTH 1 DAY 8 YEAR 84 HOUR 9 1/2 AM	
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH 12 DAY 11 YEAR 1904	6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ind.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10 CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter	
13a STATE Ind.	13b COUNTY Baltimore	13c CITY OR TOWN Baltimore	13d STREET ADDRESS 610 Myeth St. 21230	
14 FATHER'S NAME FIRST George W. LAST Brown		15 MOTHER'S MAIDEN NAME FIRST Mary P. LAST Hartlose		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 217-07-5570		
17a		17b ADDRESS Linda L. Brown 610 Myeth St. 21230		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac ArrestAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH4254
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

Congestive Cardiomyopathy

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Hepatic failure, Kidney failure - acute

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from Jan 4 , 19 84 , to Jan 8 , 19 84 , that (I) (we) lost saw the deceased alive on Jan 7 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE Victor S. Roth	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 1/8/84
22d PHYSICIAN'S NAME (TYPE OR PRINT) VICTOR S. ROTH		22e ADDRESS 700 WASHINGTON BLVD, BALTO 21230	

23a BURIAL, CREMATION, REMOVAL (CHECK) burial	23b DATE 1-11-1984	23c NAME OF CEMETERY OR CREMATORY Lakeview Mem. Pk.	23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Cecil Co. Md.
24 FUNERAL DIRECTOR John J. Cowan & Son Inc.		25a DATE REC'D. BY REGISTRAR JAN 11 1984	25b REGISTRAR'S SIGNATURE John J. Cowan



Canadian Forest

Canadian Forest

Canadian Forest

Canadian Forest

1/8/84

1/8/84

1/8/84

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 00791	
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) JOHANNA MARY G. BROWN						2a. DATE OF DEATH MONTH DAY YEAR JANUARY 7, 1984		2b. HOUR 1:45^{PM}			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 29 12		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson		12b. KIND OF BUSINESS OR INDUSTRY Real Estate			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4512 Cedar Garden Rd. 21229			
14. FATHER'S NAME FIRST MIDDLE LAST McKanzie Gibson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary C. Schwind					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 215-01-1600		17. INFORMANT ADDRESS William Gibson 4512 Cedar Garden Rd. 21229					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 8809 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) intra-cranial Hemorrhage. DUE TO, OR AS A CONSEQUENCE OF (c) Fallen down stairs.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:30 P.M. 1-7-84 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Pt fell down stairs					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4512 Cedar garden rd Baltimore Md					
22a. I certify that (I) (this hospital) attended the deceased from 1-6 , 19 84 , to 1-7 , 19 84 , that (I) (we) lost saw the deceased alive on 1-7 , 19 84 , and that in (my) (our) opinion death occurred on date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Accident											
22b. SIGNATURE Faiz M. Behsudi						DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-7-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FAIZ M. BEHSUDI						22e. ADDRESS St. Agnes Hospital, 21229					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/11/84		23c. NAME OF CEMETERY OR CREMATORY Lakeview Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Maryland			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.						24b. ADDRESS 21229		25a. DATE REC'D. BY REGISTRAR JAN 12 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

JIBE

1. The first part of the document is a list of names and addresses, which are arranged in a columnar format. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is headed by the word "List" in a large, bold font.

2. The second part of the document is a series of paragraphs, each beginning with a number. The paragraphs are written in a cursive script, and the numbers are written in a printed style. The paragraphs are arranged in a columnar format, with the numbers on the left and the text on the right.

3. The third part of the document is a series of paragraphs, each beginning with a number. The paragraphs are written in a cursive script, and the numbers are written in a printed style. The paragraphs are arranged in a columnar format, with the numbers on the left and the text on the right.

4. The fourth part of the document is a series of paragraphs, each beginning with a number. The paragraphs are written in a cursive script, and the numbers are written in a printed style. The paragraphs are arranged in a columnar format, with the numbers on the left and the text on the right.

5. The fifth part of the document is a series of paragraphs, each beginning with a number. The paragraphs are written in a cursive script, and the numbers are written in a printed style. The paragraphs are arranged in a columnar format, with the numbers on the left and the text on the right.

6. The sixth part of the document is a series of paragraphs, each beginning with a number. The paragraphs are written in a cursive script, and the numbers are written in a printed style. The paragraphs are arranged in a columnar format, with the numbers on the left and the text on the right.

7. The seventh part of the document is a series of paragraphs, each beginning with a number. The paragraphs are written in a cursive script, and the numbers are written in a printed style. The paragraphs are arranged in a columnar format, with the numbers on the left and the text on the right.

8. The eighth part of the document is a series of paragraphs, each beginning with a number. The paragraphs are written in a cursive script, and the numbers are written in a printed style. The paragraphs are arranged in a columnar format, with the numbers on the left and the text on the right.

9. The ninth part of the document is a series of paragraphs, each beginning with a number. The paragraphs are written in a cursive script, and the numbers are written in a printed style. The paragraphs are arranged in a columnar format, with the numbers on the left and the text on the right.

10. The tenth part of the document is a series of paragraphs, each beginning with a number. The paragraphs are written in a cursive script, and the numbers are written in a printed style. The paragraphs are arranged in a columnar format, with the numbers on the left and the text on the right.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 / 9 2

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) SYDNEY M. BROWN		2a. DATE OF DEATH MONTH DAY YEAR JANUARY 7, 1984	
3. SEX MALE		2b. HOUR 232 P M	
4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 26, 1915	
6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHAIRMAN OF BOARD		12b. KIND OF BUSINESS OR INDUSTRY BROWNS FURNITURE CO.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. CITY BALTIMORE 13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 3201 OLD POST DRIVE, APT. 2 (21208)	
14. FATHER'S NAME FIRST MIDDLE LAST JACOB BROWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH ROSENBLUM	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. NAVY-WWT 214-01-6113	
17. INFORMANT ADDRESS MRS. ADA BROWN 3201 OLD POST DR., APT. 2 (21208)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC & VASCULAR - multiple myocardial infarctions DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DIS. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 4 3/4			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). ANEMIA, RENAL INSUFFICIENCY			
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JAN 1983, to JAN 1984, that (I) (we) last saw the deceased alive on JAN 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Abraham Genecin MD		22c. DATE SIGNED 8 JAN 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ABRAHAM GENECIN		22e. ADDRESS 5616 CROSS COUNTRY BLVD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/9/84	
23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMINO CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215		25a. DATE REC'D. BY REGISTRAR JAN 10 1984	
25b. REGISTRAR'S SIGNATURE John J. Conner			



STANDARD
FORM NO. 1
MAY 1962 EDITION
GSA GEN. REG. NO. 27

U.S. GOVERNMENT PRINTING OFFICE

1-5810-108



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as occurring, then any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 84 000 / 93	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR MIN						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BRYANT, HENRIETTA					2a. DATE OF DEATH MONTH DAY YEAR 1/16/84					2b. HOUR MIN 20	
3. SEX F		4. RACE BLACK		5. DATE OF BIRTH 8/7/10		6. AGE (IN YEARS - LAST BIRTHDAY) 73 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.					
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY 21223		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 405 POLASKI ST. - BON SECOURS HOSP.	
14. FATHER'S NAME FIRST MIDDLE LAST SONNY MANGRUM					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EILENE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 240-09-2672D		17. INFORMANT ADDRESS Eva Hunter 3530 Ellerslie Avenue					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4273 CARDIO - RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CEREbroVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) ATRIAL FIBRILLATION										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) CONGESTIVE HEART FAILURE											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (this hospital) attended the deceased from 1/16/84 to 1/16/84, that I saw the deceased alive on 1/16/84, and that in my opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death, so state.)											
22b. SIGNATURE Howard B. Chen, M.D.					DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/17/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD B. CHEN					22e. ADDRESS BON SECOURS HOSPITAL						
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 1/20/84		23c. NAME OF CEMETERY OR CREMATORY Eastview Memorial Pk.			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME William C March F/H Inc. 1101 E North Avenue ADDRESS					25a. DATE RECEIVED BY REGISTRAR 1/19/84 REGISTRAR'S SIGNATURE John J. Carver						

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8400794

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEROY BRYANT			2a. DATE OF DEATH MONTH DAY YEAR 1 25 84		2b. HOUR M AM
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 10 27 35	6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAR.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.		
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN HOSPITAL, GIVE FULL NAME AND ADDRESS) 5436 NARCISSESS AVE.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.
14. FATHER'S NAME FIRST MIDDLE LAST JOHN BRYANT			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALMA PERRY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 243-46-3776	17. INFORMANT ADDRESS A CATHERINE McMILLEN 5436 NARCISSESS AVE.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Respiratory Failure*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH*1 day*

1629
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

*(b) Metastatic Squamous Cell Lung Cancer**2 yrs*

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/6/84</u> to <u>1/25/84</u> , that (I) (we) last saw the deceased alive on <u>1/6/84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Jeffrey Abrams</i>	DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 1/26/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey S. Abrams	22e. ADDRESS Univ. Md. Cancer Center, 22 S. Greene, Balt, Md 21201		

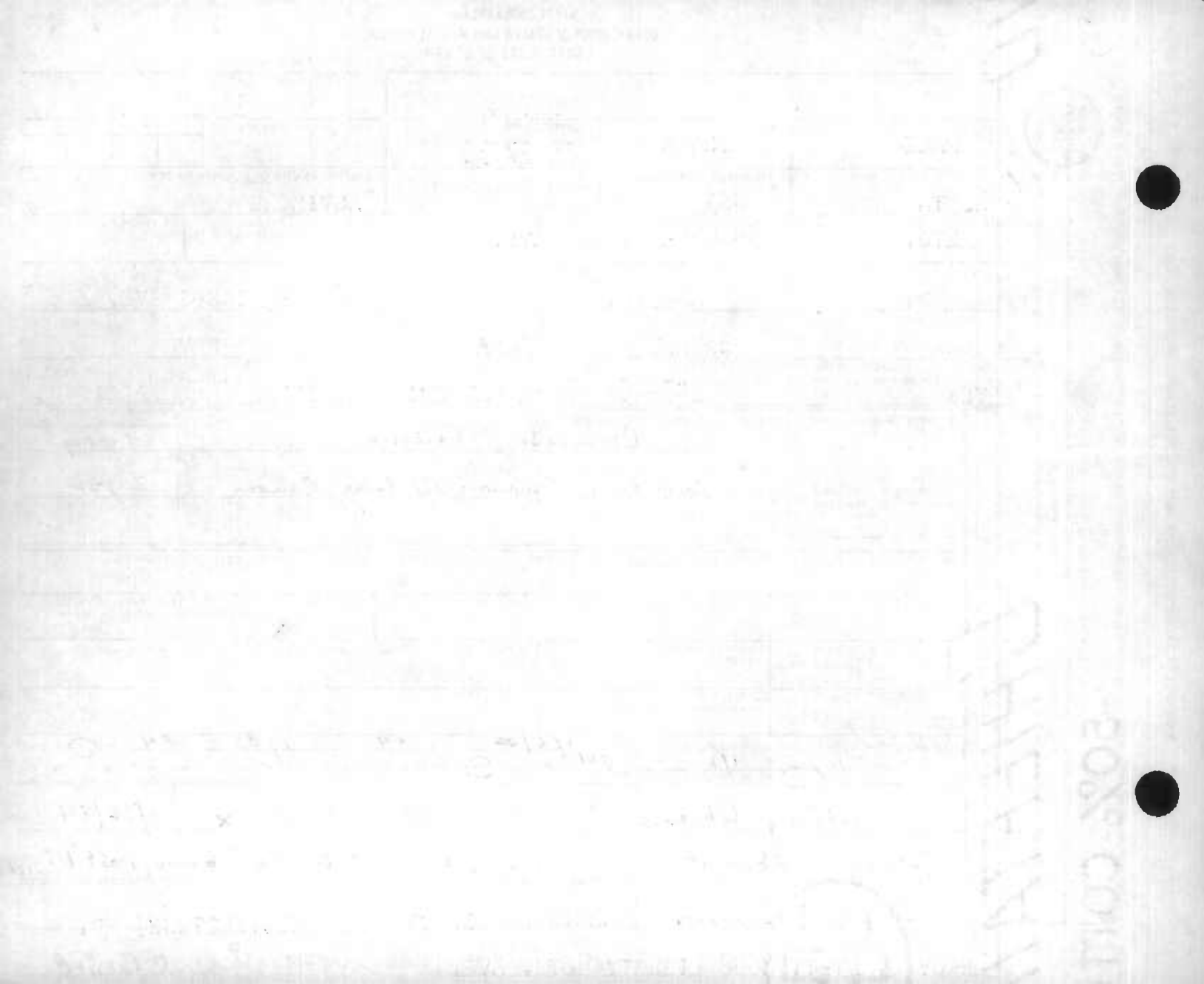
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1/30/84	23c. NAME OF CEMETERY OR CREMATORY GARRISON FORREST CEM. REISTERSTOWN, MD.	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME LEROY O. DYETT 4600 LIBERTY HGTS. AVE.		25. DATE REC'D. BY REGISTRAR JAN 30 1984	
		25. REGISTRAR'S SIGNATURE <i>Sam E. Carver</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST
H. J. HAMPFREY WARREN BUCKLER Jr.

2a. DATE OF DEATH MONTH DAY YEAR
1-15-1984

2b. HOUR MIN.
6:15 M.

3. SEX
MALE

4. RACE
WHITE

5. DATE OF BIRTH MONTH DAY YEAR
May 27, 1906

6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTO., MD.

7b. CITIZEN OF WHAT COUNTRY?
U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD.

10. CITY OR TOWN OF DEATH
BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LONG GREEN NURSING CENTER

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Attorney

12b. KIND OF BUSINESS OR INDUSTRY
(Partner)
Law Firm

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Pinehurst

13d. INSIDE CITY LIMITS?
YES ☐ NO ☒

13e. STREET ADDRESS
6303 Pinehurst Road 21212

14. FATHER'S NAME FIRST MIDDLE LAST
Humphrey Warren Buckler Sr.

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Herbert

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-32-0788

17. INFORMANT ADDRESS
Helen R. Buckler (Wife) (Same as 13e)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

3320

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☒ NO ☐YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

22a. I certify that (I) (this hospital) attended the deceased from 6-16-83 to 1-15-84, that (I) (we) lost
saw the deceased alive on 1-15-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
(above) (I) (we) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

WILLIAM G. HELFRICH MD.

5006 ROLAND AVE.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION

23b. DATE
Jan. 17, 84

23c. NAME OF CEMETERY OR CREMATORY
Green Mount Crematory

23d. LOCATION
CITY OR TOWN Baltimore City COUNTY Maryland STATE

24. FUNERAL DIRECTOR
NAME Walter Brooks Bradley, Inc.
WALTER BROOKS BRADLEY, INC., DUNDALK, MD 21222

25a. DATE REC'D. BY REGISTRAR
JAN 18 1984

25b. REGISTRAR'S SIGNATURE
John J. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 4 and 5 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

100-100000-1



100-100000-1

100-100000-1



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8400796

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ETTA BUKOWITZ			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 11 1984			2b. HOUR 8:51 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1 15 04		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
12b. KIND OF BUSINESS OR INDUSTRY AT HOME		13a. STREET ADDRESS 3101 SHELBOURNE RD		13b. CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS 21208	
14. FATHER'S NAME FIRST MIDDLE LAST MORITZ GROSSMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLIE GROSSMAN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-48-5279	
17. INFORMANT MORITZ BUKOWITZ		18. LONGNECKER RD.		REISTERSTOWN, MD		21136	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

0389 IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) SEPSIS
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

(R) CEREBRAL VASCULAR ACCIDENT

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1-11 1984, to 1/11 1984, that (I) (we) lost saw the deceased alive on 1-11 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE K. G. & P. G.				DEGREE MD		22c. DATE SIGNED 1-11-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. COLLIER				22e. ADDRESS SINAI HOSPITAL			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 13, 1984		23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MEN		23d. LOCATION BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR JAN 17 1984		25b. REGISTRAR'S SIGNATURE John J. Collier	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1954 10 10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Andrew Burbul			2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 1-31 1984			2b. HOUR M 7:25 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4 21 21	6. AGE (IN YEARS) (LAST BIRTHDAY) 62 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD 1-31 1984	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED XX DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (Soc. Services)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 507 East Ave. 21222
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unkn.		(IF YES, GIVE WAR OR GATES)		16b. SOCIAL SECURITY NO. 283-14-6423		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO XX
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection XX Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes XX Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Dennis F. Smyth, M.D.				TITLE (SPECIFY) M.D. Assistant		DATE SIGNED 2-1-84	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 2/16/84		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a. DATE RECD. BY REGISTRAR FEB 22 1984	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

1011

1011

1011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 4 0 0 / 9 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) HEATHER RENEE BURCHETTE				2a. DATE OF DEATH MONTH DAY YEAR Jan 17 1984			
3. SEX FEMALE				4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 30, 1983	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS.		8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 18	
10. CITY OR TOWN OF DEATH BALTIMORE				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A				12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. STATE MD				13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE de GRACE	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 139 NORTH WASHINGTON ST. 21078			
14. FATHER'S NAME FIRST MIDDLE LAST IVON RAY BURCHETTE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SHARON LEE NELSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS MRS. SHARON LEE BURCHETTE SAME AS #13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brucella, hypotensive</u> 7651 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Thrombotic hemorrhage, hypovolemic shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>preexisting</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-30</u> , 19 <u>83</u> , to <u>1-17</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>1-17-84</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Hawz</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>1/18/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Siggo Sawzola Pena</u>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 20 JANUARY 84		23c. NAME OF CEMETERY OR CREMATORY BEL AIR MEMORIAL GARDENS		23d. LOCATION CITY OR TOWN COUNTY STATE BEL AIR, HARFORD CO, MARYLAND	
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078				25a. DATE REC'D. BY REGISTRAR <u>23 JAN 1984</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

10/10/10



10/10/10

MED 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR					STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) MIKE (MICHAEL) (BERGER) Burger					2a. DATE OF DEATH MONTH DAY YEAR 01/19/84					2b. HOUR 12:53pm					
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 5 1 1914		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.									
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 225 N. Dallas Ct 21231							
14. FATHER'S NAME FIRST MIDDLE LAST James Burger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Judy Johnson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 219-05-4407		17. INFORMANT ADDRESS Sarah Streams 225 N. Dallas Court									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest 1173 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hemoptysis (c) aspergilloma										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes 40 minutes 6 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Chronic obstructive pulmonary disease															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) this hospital attended the deceased from 1/19/84 to 1/19/84, that (I) saw the deceased alive on 1/19/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE S. M. Hines M.D., Ph.D.										DEGREE		22c. DATE SIGNED 1/19/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. M. Hines										22e. ADDRESS Johns Hopkins Hospital Baltimore, Md. 21205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/24/84		23c. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md					
24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Avenue										25a. DATE REC'D. BY REGISTRAR JAN 23 1984		25b. REGISTRAR'S SIGNATURE John J. Larrick			

BP

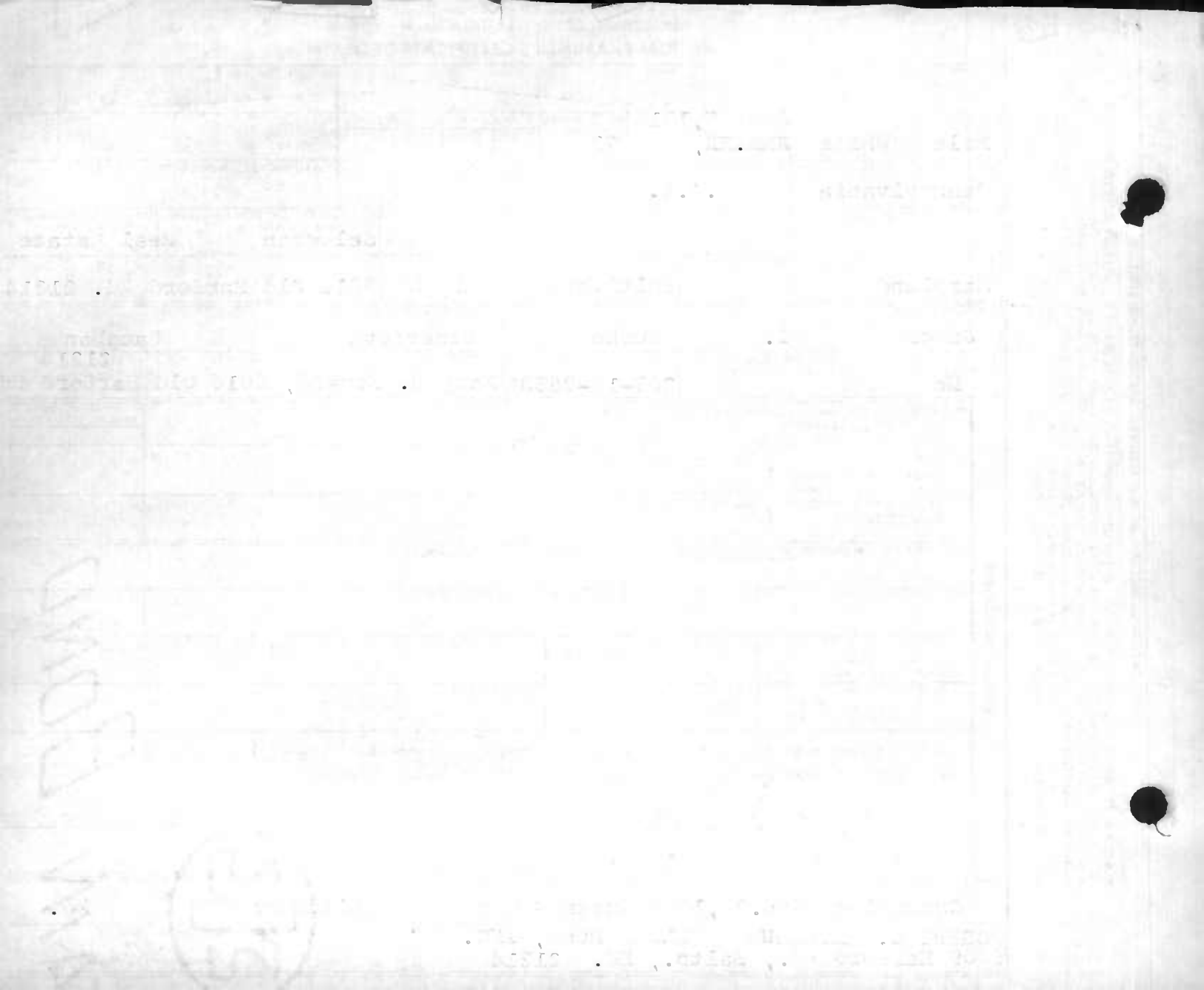
60

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

FOR STATE REGISTRAR				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) George J. Burke				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 1 DAY 23 YEAR 84				2b. HOUR 9:05			
3 SEX Male		4 RACE White		5. AGE (IN YEARS) 73 YRS.		6. IF UNDER 1 YR. MONTHS 0 DAYS 0		7c. DATE PRONOUNCED DEAD 1/23/84		7d. HOUR 9:05	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BaltimoreCity MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6016 Old Harford Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Real Estate			
13a. STATE Maryland				13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 6016 Old Harford Rd. 21214			
14. FATHER'S NAME James T. Burke				15. MOTHER'S MAIDEN NAME Genevieve Gaughan				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 207-10-0550A				17. INFORMANT Mary R. Howard				17. ADDRESS 21214 6016 Old Harford Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 1/23/84			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE Jan. 24, 1984		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR ROBERT C. ALTENBERG						25a. DATE REC'D. BY REGISTRAR JAN 26 1984		25b. REGISTRAR'S SIGNATURE [Signature]			
6009 Harford Rd., Balto., Md. 21214											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the appropriate death certificate file. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84 00801

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GOLDEN BURKE			2a. DATE OF DEATH MONTH DAY YEAR 1 22 84			2b. HOUR 10:30 P				
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR SEPT 2 1918		6. AGE (IN YEARS LAST BIRTHDAY) 65		7. IF UNDER 1 YEAR MONTHS DAYS YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? US of A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PROVIDENT HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY SCHOOL CUSTODIAN		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND			13b. COUNTY BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2318 KOKO LANE 21216			
14. FATHER'S NAME GEORGE HENRY BEVANS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINERVA GASKINS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 217 03 8013B	
17. INFORMANT MRS. FANNIE B. POULSON			ADDRESS 2318 KOKO LANE 21216			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) UNCONTROLLED HYPERTENSION				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from 1/22 19 84, to 1/22 19 84, that (I) (we) last saw the deceased alive on 1/22 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature]			DEGREE MD			22c. DATE SIGNED 1/22/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. OBIDHA, MD			22e. ADDRESS 2600 LIBERTY HEIGHTS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1/28/84		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE (BALTO.) MD			
24. FUNERAL DIRECTOR LEWIS T. GWYNN			4517 PARK HEIGHTS AVENUE			25a. DATE REC'D. BY REGISTRAR JAN 24 1984		25b. REGISTRAR'S SIGNATURE [Signature]		

BP

3

REMARKS

BLACK

DATE 5 1913

65

X

US OF A

REMARKS

REMARKS

REMARKS

X

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

NO

DATE 03 30 1913

MR. FANNIE B. HOLLAND

DATE 03 30 1913

REMARKS

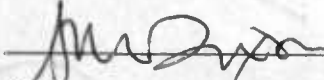

DATE 03 30 1913

REMARKS

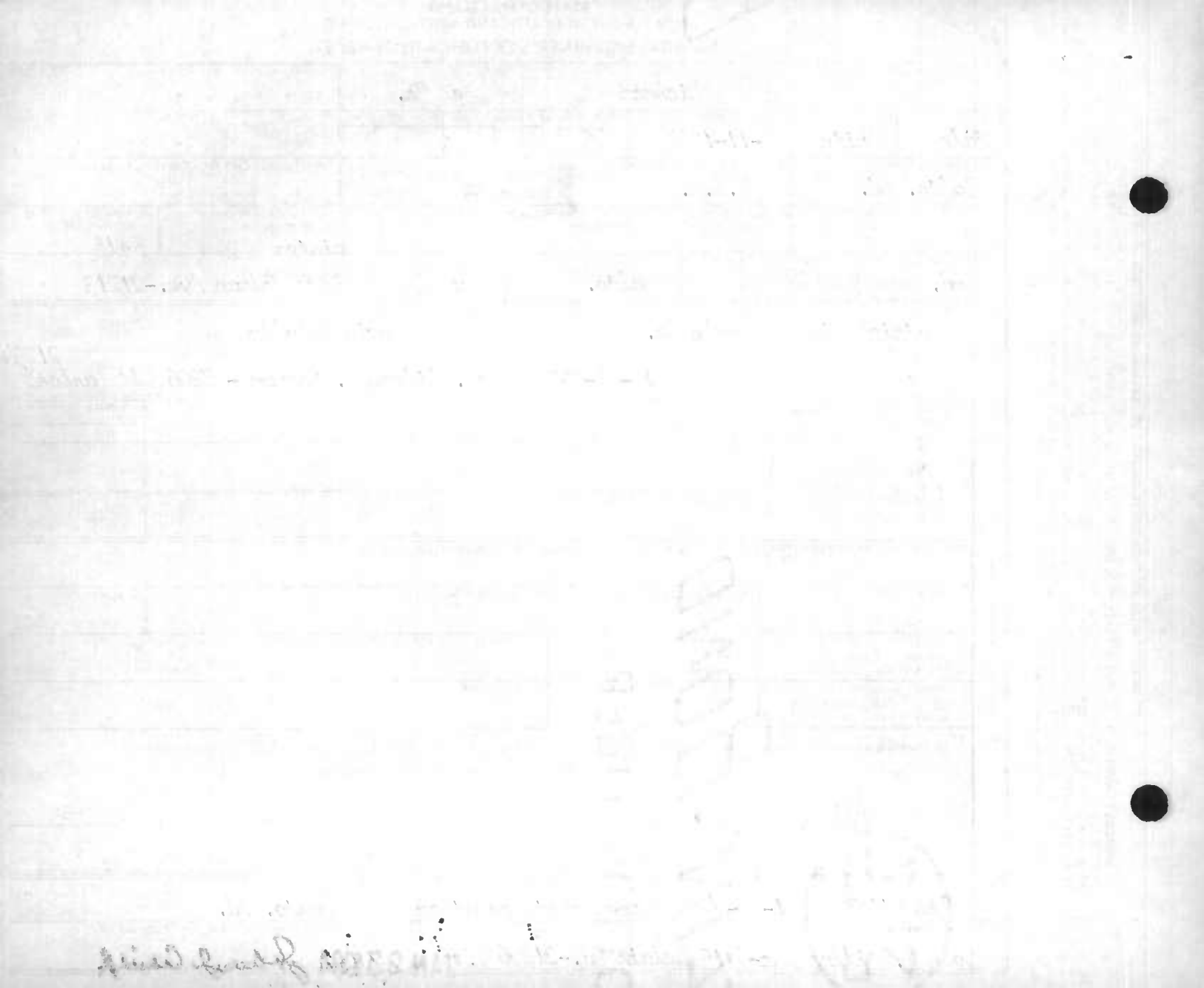
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 4 0 0 8 0 2	
FOR 1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		26. HOUR	
PATRICK		Richard		BURK		e Jr.		21. DATE PRONOUNCED DEAD		24. HOUR	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5-11-1937		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. MONTH DAY YEAR 1 18 1984	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3228 Brendle Ct.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Self					
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3300 Erdman Ave.-21213			
14. FATHER'S NAME FIRST MIDDLE LAST Patrick Richard Burke Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delia Schultzy									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-34-0872		17. INFORMANT ADDRESS Mrs. Eileen B. Kramme - 8206 Old Harford Rd						21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 3a30 IMMEDIATE CAUSE (a) <u>Alcoholism</u> Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED		1-19-84			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., Md.		21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1-20-84		23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory		23d. LOCATION CITY OR TOWN Balto. Md.		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE 					

JAN 23 1984



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4

0 0 8 0 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Winifred T. Burke			2a. DATE OF DEATH MONTH DAY YEAR Jan 4 1984 3:38 PM		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 01 02 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. JENKINS HOSPITAL NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1000 S. Caton Ave. Balt; Md. 21229		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner	
12b. KIND OF BUSINESS OR INDUSTRY Tavern					
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Nolan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Penelope Healy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-34-6376		17. INFORMANT ADDRESS Robert G. Hewitt 330 Small Court, 21228	
18. CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c) PART 1. DEATH WAS CAUSED BY: 4292 Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (a) disease DUE TO, OR AS A CONSEQUENCE OF (b) yes DUE TO, OR AS A CONSEQUENCE OF (c) yes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 1-3 , 19 84 , to 1-4 , 19 84 , that he (we) last saw the deceased alive on 1-3 , 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, we (we) did not see the body after death.					
22b. SIGNATURE Laurence R. Gallagher, MD PHYSICIAN'S NAME (TYPE OR PRINT)		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-4-84	
22d. ADDRESS LAURENCE R. GALLAGHER, M.D.		ST. AGNES MEDICAL CENTER, 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01-07-84		23c. NAME OF CEMETERY OR CREMATORY New Cathedral	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR JAN 5 1984		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the case.

100-1000

100-1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and that it be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 4 0 0 8 0 4	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH							
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST <i>William Robert Burns</i>				MONTH DAY YEAR <i>1-9-84</i>				P. M. <i>10:30 M</i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10-14-1924</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>59</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.					
10. CITY OR TOWN OF DEATH <i>U.S.A.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Memorial Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Maintenance Sup.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Wynwood Towers</i>			
13a. STATE <i>MD.</i>				13b. COUNTY <i>Baltimore</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <i>100 W. Cold Spring Lane</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Unknown</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Belva Foote</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>				16b. SOCIAL SECURITY NO. <i>217-16-0471</i>		17. INFORMANT ADDRESS <i>Catherine V. Burns - 100 W. Cold Spring Lane</i>					
18. CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic heart disease angina</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>4100</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i> <i>9 years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>—</i>											
19a. DATE OF OPERATION <i>—</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>9 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>December 10, 1982</i> to <i>January 9, 1984</i> , that (I) (we) last saw the deceased alive on <i>January 9, 1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (not) view the body after death.											
22b. SIGNATURE <i>E. J. Alessi</i>				DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>1/10/84</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. J. Alessi; M.D.</i>				22e. ADDRESS <i>6217 Harford Rd Baltimore Md 21214</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>1-13-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md.</i>			
24. FUNERAL DIRECTOR NAME <i>John C. Miller Inc.</i>						ADDRESS <i>415 Belair Rd. - 21206</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 13 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>	

Handwritten notes on lined paper, including a large 'E' at the top left, a date '1/10/84', and a signature 'E. J. Alessi'.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Linda Burrell			2a. DATE OF DEATH MONTH DAY YEAR 1 13 84			2b. HOUR 10 ⁴⁵ AM			
3. SEX Female		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 11 22 52		6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) M.D.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.			
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bank teller		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE M.D.		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3419 Elmore Ave. #21213	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Willis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Mae Willis			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 213-58-1230			17. INFORMANT ADDRESS #21213 MRS. ELLA MAE WILLIS 3419 Elmore Ave			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Leukopenia Pleural Peritoneal Carcinomatosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 1/13/84 to 1/13/84, that (1) (we) last saw the deceased alive on 1/13/84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above.									
22b. SIGNATURE MARVIN FELDMAN				DEGREE				22c. DATE SIGNED 1/13/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR MARVIN FELDMAN				22e. ADDRESS MERCY HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-17-84		23c. NAME OF CEMETERY OR CREMATORY BALTO. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.			
24. FUNERAL DIRECTOR NAME Betts Funeral Home				ADDRESS 1129 N. Caroline St.		25a. DATE REC'D. BY REGISTRAR JAN 17 1984		25b. REGISTRAR'S SIGNATURE Sam J. Carver	

BP



BOX 2 CULL
CHILLER



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 0 6

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Steven M. (Burrell) Burrell			2a. DATE OF DEATH MONTH DAY YEAR 1 19 84			2b. HOUR 6a.m.			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 11 65		6. AGE (IN YEARS LAST BIRTHDAY) 18 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wyman Park Health System				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS 4802 Norwood Road 21212									
14. FATHER'S NAME FIRST MIDDLE LAST (Russell) BURRELL (Burrell)					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Jessie) BURRELL (Mc Glendon)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 219-86-7451				
17. ADDRESS Russell Burrell 807 Avondale Road					17. ADDRESS Dr. Levinger, Wyman Park Health System				

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Massive G. I. Bleed

0709
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) Fulminant Hepatitis

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Cerebral Hemorrhage

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William A. Levinger, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/19/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William A. Levinger, M.D.				22e. ADDRESS 3100 Wyman Park Drive Baltimore, Maryland 21211			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/24/84		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Co, Md.	
--	--	----------------------	--	---	--	--	--

24. FUNERAL DIRECTOR NAME William C March F/H Inc. 1101 E North Avenue		25a. DATE REC'D. BY REGISTRAR JAN 20 1984		25b. REGISTRAR'S SIGNATURE John J. Conner	
--	--	--	--	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8400807

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Marjorie Butler		2a. DATE OF DEATH MONTH DAY YEAR 1-24-84		2b. HOUR M	
3. SEX Female		4. RACE Col. 7		5. DATE OF BIRTH MONTH DAY YEAR 7-6-96		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2424 Eutaw Place		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ISAIAH COLLICK COLLINS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GEORGANNIA SPENCER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS Mrs. Jean Wright 2424 Eutaw Place		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 KIDNEY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH NOT KNOWN NOT KNOWN			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) REPEATED STROKES							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John B. De Hoff		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 27 Jan 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John B. De Hoff, MD		22e. ADDRESS Balto. City Health Dept. 111 N. Calvert Street, Balto. 21202					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-28-84		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, MD	
24. FUNERAL DIRECTOR NAME Joseph L. Russ		ADDRESS 2222 W. North Ave.		25a. DATE REC'D. BY REGISTRAR JAN 27 1984		25b. REGISTRAR'S SIGNATURE John L. Collins	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

RECEIVED
JAN 11 1902

1 24 17

Butter

Wagon

Butter

1 24

1 24

Wagon

Wagon

Wagon

Wagon

Wagon

Wagon

Wagon

Wagon

Wagon

Wagon

Wagon

Wagon

Wagon

Wagon

Wagon

Wagon

Wagon

Wagon

Wagon

Wagon

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 0 8

1- FOR
STATE
REGISTRAR

REG. NO.

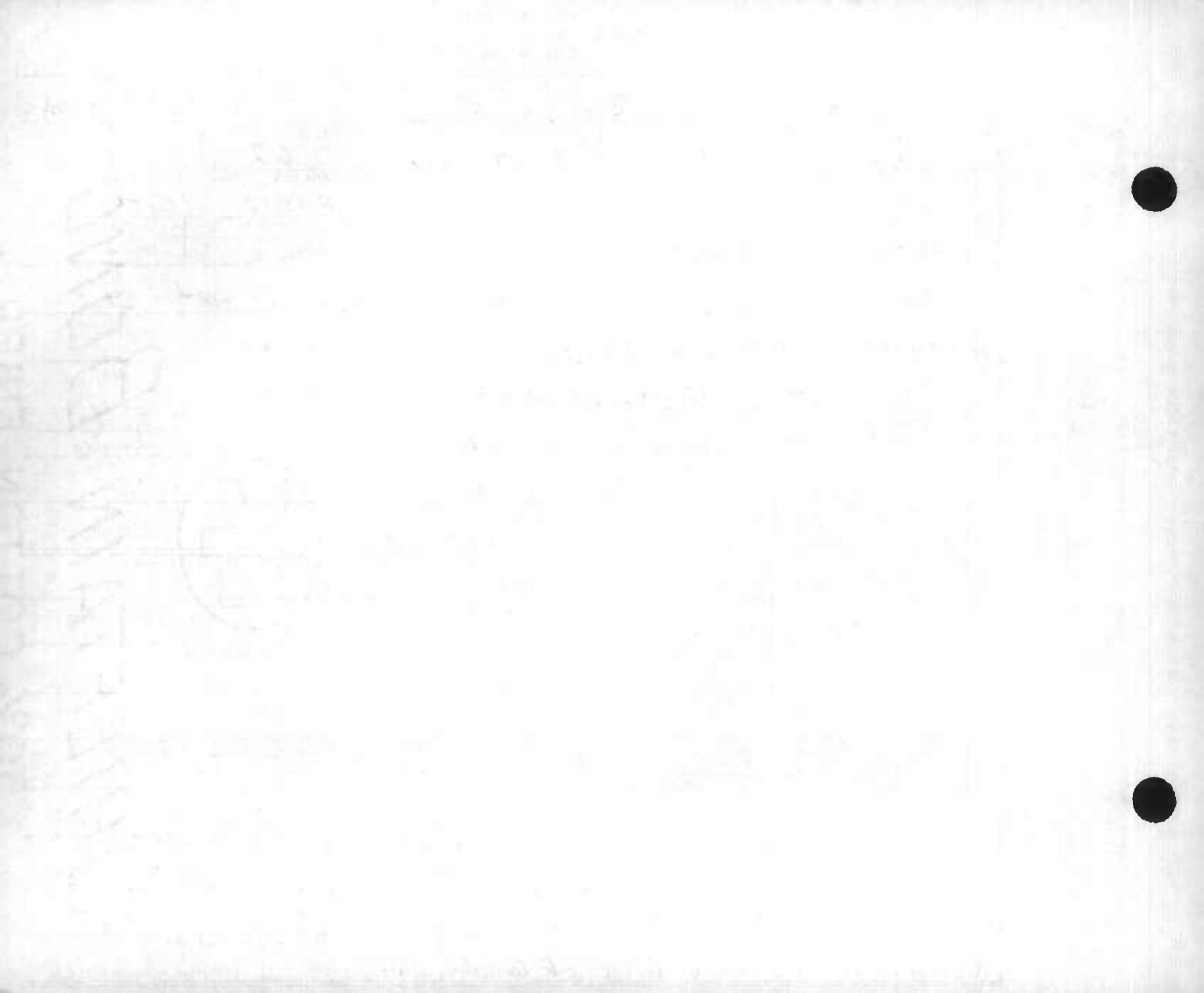
1. DECEASED NAME (TYPE OR PRINT) Mary Buzgierski			2a. DATE OF DEATH MONTH DAY YEAR 1 22 84			2b. HOUR 11:00A _M			
3. SEX F.		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 7 04 1921		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.			
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. CITY HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSWE		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE MD			13b. COUNTY BALTO.		13c. CITY OR TOWN		13d. STREET ADDRESS 1301 S. 48th St.		
14. FATHER'S NAME FIRST MIDDLE LAST ANTHONY MOSCIEWOJEWSKI				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 219-03-6901		17. INFORMANT ADDRESS ANDREW BUZGIERSKI				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4920 IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary congestion DUE TO, OR AS A CONSEQUENCE OF (c) S/P Myxoma, Thoracotomy APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Days Weeks									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Severe anoxic encephalopathy									
19a. DATE OF OPERATION 12.15.83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Emyema			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10.21.83 to 1.22.84, that (I) (we) lost saw the deceased alive on 1.22.84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE RICHARD CHEN			DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1.22.84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD CHEN			22e. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTO.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1/25/84		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.		
24. FUNERAL DIRECTOR NAME CONNELLY FUNERAL HOME OF DUNDACK					25a. DATE REC'D. BY REGISTRAR JAN 26 1984		25b. REGISTRAR'S SIGNATURE - [Signature]		

35
31
30
2

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical certificate must be filed with the State Dept. of Health and Mental Hygiene.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medicolegal certificate must be certified for one.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		1		21 84 M	
CLIFTON H. BYERS											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Black		MONTH DAY YEAR 12 28 34		49 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore City, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		6309 LAURELTON AVENUE									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6309 Laurelton Ave.		21214	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST Garfield Randolph		FIRST MIDDLE LAST Myrtle Byers									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
YES		216-36-2104		Sandra Byers		6309 Laurelton Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
2050		acute myelogenous leukemia								18 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		leukopenia thrombopenia, disseminated fungal infection									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
N/A		N/A		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
		HOUR A.M. MONTH DAY YEAR P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
8/22/82, 19 82, to 8/22/84, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		Richard L. Humphrey		M.D.				8/23/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Richard L. Humphrey		The Johns Hopkins Oncology Center									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
BURIAL		1/27/84		Baltimore Cemetery		Baltimore				MD.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Wm C March F/H Inc. 1101 E North Avenue		JAN 24 1984		John J. Carver							

1947-1948
1949-1950
1951-1952



CHIEF OF BUREAU



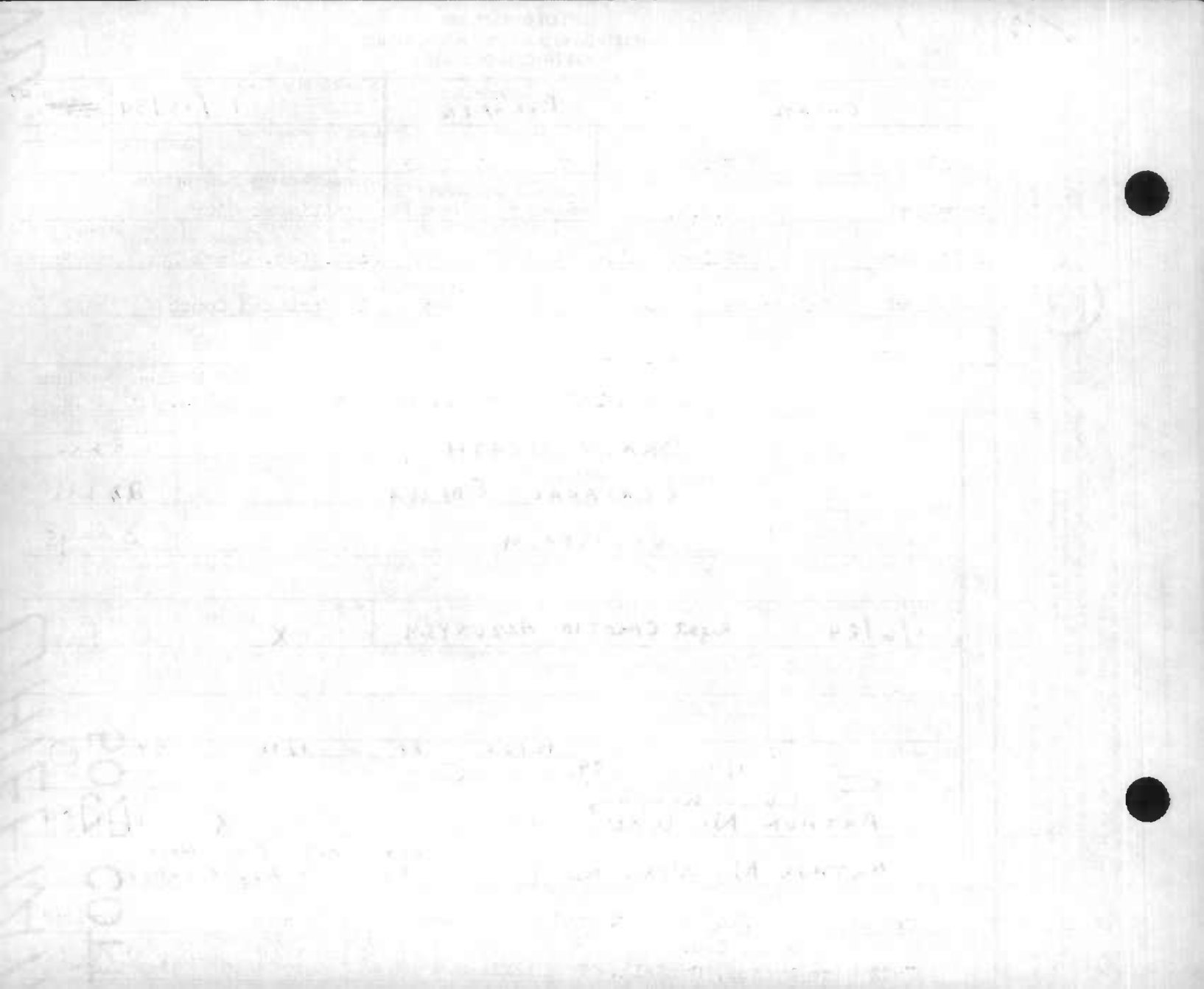
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to autopsify.1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST Cheryl MIDDLE A. LAST Bynaker CHEYL BYNAKER		2a. DATE OF DEATH MONTH 1 DAY 11 YEAR 1984		2b. HOUR 5:07 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 7 DAY 26 YEAR 1949		6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Acct. Rec. Clerk		12b. KIND OF BUSINESS OR INDUSTRY Better Business Forms
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Essex	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10 Masthead Court 21221
14. FATHER'S NAME FIRST Delbert MIDDLE CLAYTON LAST Sr.		15. MOTHER'S MAIDEN NAME FIRST Sarah MIDDLE BROWN LAST Brown		ADDRESS 10 Masthead Court Balto. MD 21221	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-54-1652		17. INFORMANT Harry L. Bynaker	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4439 IMMEDIATE CAUSE (a) BRAIN DEATH DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CEREBRAL EDEMA DUE TO, OR AS A CONSEQUENCE OF (c) VASOSPASM APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs 24 hrs 3 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CONTRIBUTING TO DEATH					
19a. DATE OF OPERATION 1/6/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Right CAROTID ANEURYSM		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 12/25 , 19 84 , to 1/11 , 19 84 , that (1) we last saw the deceased alive on 1/11 , 19 84 , and that in (my) <input checked="" type="radio"/> opinion death occurred on the date and hour and from the causes stated above, (1) we (did) (did not) view the body after death.					
22b. SIGNATURE Arthur N. Wang, M.D.		DEGREE ARTHUR N. WANG, M.D.		22c. DATE SIGNED 1/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR N. WANG, MD		22e. ADDRESS 610 BALTO. CITY HOSP. DEPT OF NEUROSURGERY			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1/16/84		23c. NAME OF CEMETERY OR CREMATORY Westview Cemetery	
23d. LOCATION CITY OR TOWN Baltimore		COUNTY Maryland		STATE	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue, Dundalk, MD 21222		25a. DATE REC'D. BY REGISTRAR JAN 17 1984		25b. REGISTRAR'S SIGNATURE John J. Connel	

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #M-3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1, AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(V.R. A) 5 ME (1)
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
Buster						Byrd		8		1-20-84						9:40a					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Male		Black		6 24 20		63 YRS.						1-20-84								9:40a	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. NEVER MARRIED		10. WIDOWED		11. DIVORCED		12. BALTIMORE CITY OR COUNTY OF DEATH									
N, Carolina		U.S.A.										Baltimore City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Baltimore		3607 Reisterstown Rd.																			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3607 Reisterstown Rd.												21215	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
Major		Byrd		Hattie		Byrd															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
YES		245-07-9879		Ruth Byrd		3607 Reisterstown Road															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
4292																					
								</													

(A)

IND

(A)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 1 2

1 - FOR
STATE
REGISTRAR

REG. NO

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2. DATE OF DEATH		MONTH DAY YEAR		3. HOUR	
CATHERINE M. CADDEN				JANUARY 24, 1984		6:55 p.m.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
FEMALE		WHITE		MONTH DAY YEAR Oct. 30 1903		80 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MD.		U.S.A.				BALTIMORE CITY		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		CHURCH HOSPITAL CORP.		HOMEMAKER		-			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD.		-		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4108 PARKSIDE DRIVE 21206	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
-		MOENIUS		UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS			
NO		217-62-3277		MILDRED FINK (DGHTR)		448 LAMBERT CT. 21227			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SACRAL DECUBITUS ULCERS WITH SEPSIS 7070 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SACRAL DECUBITUS ULCERS WITH SEPSIS (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from JAN 17 19 84, to JAN 24 19 84, that (I) (we) last saw the deceased alive on JAN 24 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Sompalli Prasad								22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. PRASAD SOMPALLI, M.D.								22e. ADDRESS CHURCH HOSPITAL 21231 XXXXXX 100 N. BROADWAY BALTO. MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		1/28/84		Holy REdeemer		Baltimore MD.			
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213					JAN 27 1984		[Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon-copy. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18, only injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 1 3

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) AKA FIRST HILDA MIDDLE E. LAST McCANN				2a. DATE OF DEATH MONTH DAY YEAR 11/16/84		2b. HOUR 3:15 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 19 03		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY	
12b. KIND OF BUSINESS OR INDUSTRY PACKING CO.							
13a. STATE MARYLAND		13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 3200 BENSON AVENUE, 21227							
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH BAIERLIPP				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELSIE CARMINE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT ALICE M. BECKER			
				ADDRESS 5011 GATEWAY TERRACE, 21227			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 2113 DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 days 20 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: MULTIPLE POLYPOSIS, RIGHT COLON							
19a. DATE OF OPERATION 12/8/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED MULTIPLE POLYPOSIS, RIGHT COLON		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JAN 15 19 84 to JAN 16 19 84 , that (I) (we) last saw the deceased alive on JAN 16 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Michael G. Macdon				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL G. MACDON				22e. ADDRESS 900 CATON AVE. BALT MD 21229.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 01-19-84		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.				25a. DATE REC'D. BY REGISTRAR JAN 17 1984			
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP

RECEIVED

1911

1911



RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 1 4

FOR
STATE
REGISTRAR

REG. NO.

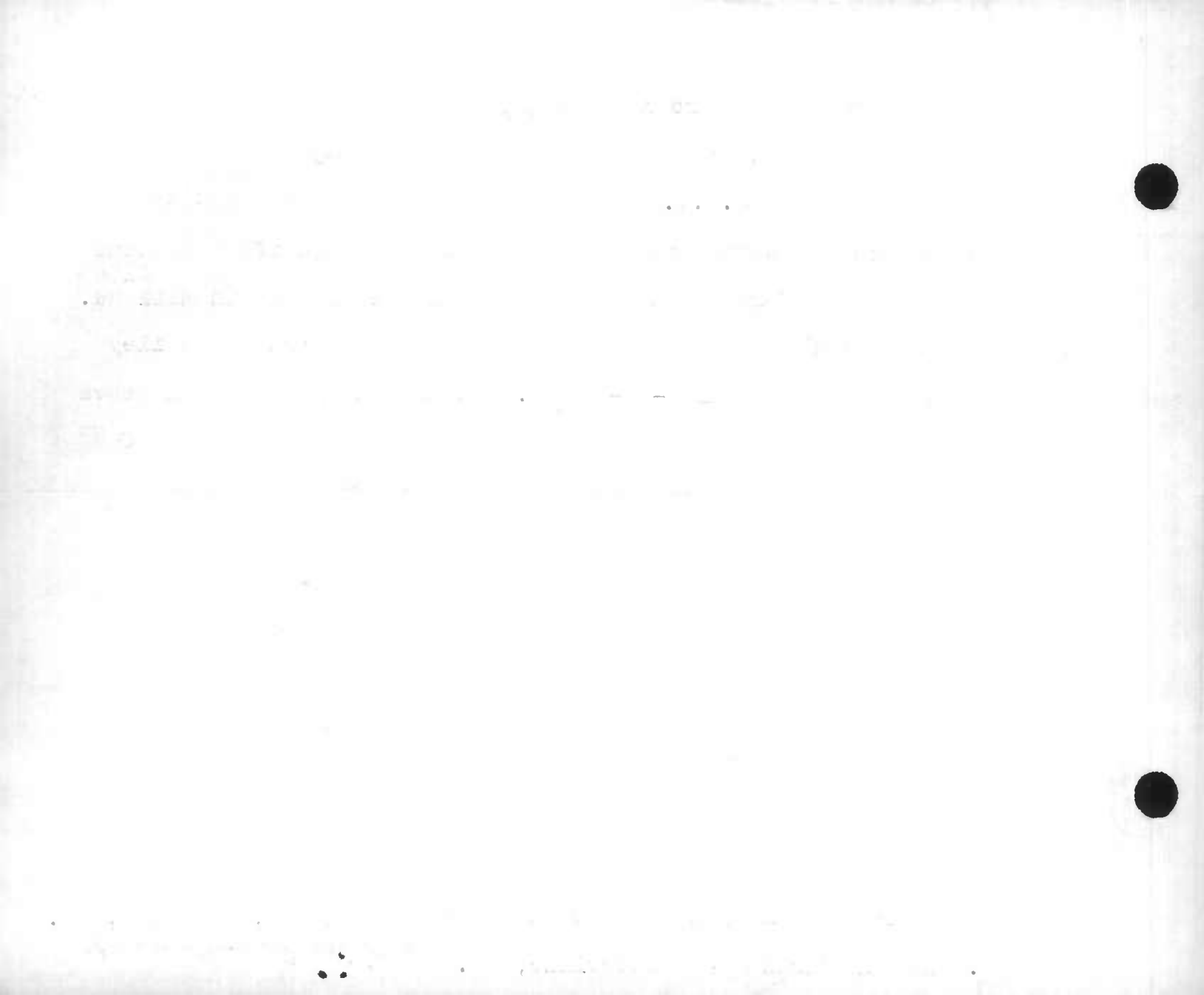
1. DECEASED NAME (TYPE OR PRINT) Gloria Brown Calary			2a. DATE OF DEATH MONTH DAY YEAR 01 20 84		2b. HOUR 3:00 PM				
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 9 18 34		6 AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH County City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Jarrettsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1221 Baldwin Mill Rd. 21084	
14. FATHER'S NAME FIRST MIDDLE LAST John Jefferson Brown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara Margaret Bailey						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 186-26-9833		17. INFORMANT ADDRESS C. Arthur Calary same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Encephalopathy 1749 DUE TO, OR AS A CONSEQUENCE OF (b) metastasis (hepatic) from adenocarcinoma of breast DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1/20/84					
22a. I certify that (I) (this hospital) attended the deceased from 1/17/84 , 19____, to 1/20/84 , 19____, that (I) (we) lost saw the deceased alive on 1/20/84 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Jyotin Parikh				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/20/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JYOTIN PARIKH				22e. ADDRESS GOOD SAMARITAN HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/23/1984		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Madonna Harford, Md.			
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz				ADDRESS Jarrettsville, Md.		25. DATED AND PLACE OF REGISTRATION JAN 23 1984			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 1 5

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George D. CALVERT			2a. DATE OF DEATH MONTH DAY YEAR 1 31 84		2b. HOUR 5:45 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 07 29 12	6. AGE (IN YEARS LAST BIRTHDAY) 71	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH Baltimore, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meacham		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TREASURER		12b. KIND OF BUSINESS OR INDUSTRY OIL CO.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST RICHARD C.M. CALVERT			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ZOE AMMON DAVIS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 244-18-7127	17. INFORMANT ADDRESS MR. G. DAVIS CALVERT 212 HOPKINS RD. 21212		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Invasive Carcinoma of Tongue 1419 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET 307 St. Paul Place	CITY OR TOWN COUNTY STATE
22a. I certify that (1) (this hospital) attended the deceased from March 19 73 to January 31 19 84 , that (1) (we) lost saw the deceased alive on January 31 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did/did not view the body after death.			
22b. SIGNATURE D. C. ALEVIZATOIS, MD		DEGREE MD	22c. DATE SIGNED 1/31/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. C. ALEVIZATOIS, MD		22e. ADDRESS 307 St. Paul Place	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE FEB. 4, 1984	23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEM.	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.

24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME	ADDRESS 6500 YORK RD. 21212	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE De 2 Card
--	---------------------------------------	-------------------------------	--

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1972 10 1

CAUGHT

200

1000000000

100

1000000000

1000000000

1000000000

100%

1000000000

1000000000

1000000000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 3 1 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bernetha J. Campbell BERNETHA. CAMPBELL			2a. DATE OF DEATH MONTH DAY YEAR 11/19/84			2b. HOUR 5:40 AM			
3. SEX F		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 6 12		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE D.C. COUNTY Washington		13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 2107 G St. N.E. 99999			
--	--	--	--	---	--	--	--	--	--

14. FATHER'S NAME FIRST John MIDDLE E. LAST Jackson		15. MOTHER'S MAIDEN NAME FIRST Carrie MIDDLE Peterson LAST Peterson	
---	--	---	--

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-30-2594		17. INFORMANT ADDRESS Rosa Lee Bennett 817 Tuskeegie St.	
--	--	--	--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) CARDIO PULMONARY Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b)			
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION 11/19/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
---	--	--	--	---	--	--	--

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
--	--	--	--	--	--	--	--

21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
--	--	--	--	---	--

22a. I certify that (I) (this hospital) attended the deceased from 11/5/84 , 19____, to 11/19/84 , 19____, that (I) (we) last saw the deceased alive on 11/19/84 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
--	--

22b. SIGNATURE LAWRENCE WELLS		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/19/84	
---	--	---	--	-------------------------------------	--

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Laurence Wells MD		22e. ADDRESS HELENE FULD Nursing School 3100 TAWAND AVE BALTIMORE, MD. 21215			
---	--	--	--	--	--

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/21/84		23c. NAME OF CEMETERY OR CREMATORY Centerville A.M.E.		23d. LOCATION CITY OR TOWN COUNTY STATE Hartsville S.C.	
--	--	-----------------------------	--	---	--	--	--

24. FUNERAL DIRECTOR NAME Wm. C. March F/H ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JAN 20 1984		25b. REGISTRAR'S SIGNATURE John J. Connel	
--	--	---	--	---	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

A

General Campbell

United

Baltimore

General Campbell

1864

1864

1864

Lawrence M. ...

James M. ...

These are the ...

1864

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked positive, 18 within any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 1 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles E Canapp			2a. DATE OF DEATH MONTH DAY YEAR 1 6 84			2b. HOUR 1228AM				
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 9 32		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hosp, Balto. Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) City Sewage Dept.		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY -----		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Balto. Md. 114 Wash. Blvd. 21230	
14. FATHER'S NAME FIRST MIDDLE LAST George I. Jackson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn ----- Finch							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 216-28-9529		17. INFORMANT ADDRESS Mrs. Bridget Canapp, Same as Above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4275 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 35 min		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: id										
19a. DATE OF OPERATION -----			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -----			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTINUING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from January 5 , 19 84 , to Jan 6 , 19 84 , that (I) (we) last saw the deceased alive on Jan 6 , 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.										
22b. SIGNATURE E. Bessman MD			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/6/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bessman			22e. ADDRESS 22 S Green St Balto 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 9, 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Mcully Funeral Home, 130 E. Fort Ave. Balto. Md.					25a. DATE REC'D. BY REGISTRAR JAN 10 1984		25b. REGISTRAR'S SIGNATURE John J. Smith			

12 8 4 E



[Faint, mostly illegible handwritten text follows, likely a technical report or log entry.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

999999
DHMH - 17
(M, A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.
1- STATE REGISTRAR												
1. DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH MATED			2b. HOUR
LINDA MARIE CARBAUGH									MONTH DAY YEAR 1-20-84			19
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
Fem.	White	Apr. 28, 1965		18 YRS.	MONTHS DAYS	HOURS MIN.	1-20-84		19		12:04 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Pa.		USA						Baltimore City MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		University Hospital STU				Med. secretary		Health				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Pa.		Franklin		Montgomery Twp.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7349 Corner Rd. 99999				
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST						FIRST MIDDLE LAST						
Gerald C. Carbaugh						Janet M. Keefer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No						159-52-6171		7349 Corner Rd. Gerald C. Carbaugh Mercersburg, Pa.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). - PART 1 DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Cranio-cervical trauma												
8120 DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
				8:55 AM MONTH DAY YEAR P.M. 1-17-84		driver of auto/auto collision						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION						
				hwy.		Penn Rt. 16 .2/10mi. East Franklin Co. Washington Township, Pennsylvania						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE						TITLE (SPECIFY)		DATE SIGNED				
Margarita A. Korell						M.D. Assistant		1-20-84				
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS						
Margarita A. Korell, M.D.						111 Penn Street						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION				
Burial				1/23/84		Fairview		Mercersburg Franklin Pa.				
24. FUNERAL DIRECTOR						17236		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
M. Sminger						Mercersburg, Pa.		JAN 24 1984				



1911

10.

1911

1911

1911

1911

10.

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 1 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST JESSE	MIDDLE J	LAST CARLOS	2a. DATE OF DEATH		MONTH 01	DAY 17	YEAR 84	2b. HOUR 12:50 A	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) South Carolina		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 530 N. Carrollton Avenue			
14. FATHER'S NAME FIRST Jesse				15. MOTHER'S MAIDEN NAME FIRST UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE DATE OF ENTRY AND DATE OF DISCHARGE) UNKNOWN		16b. SOCIAL SECURITY NO. 250-32-0220		17. INFORMANT Lamont Carlos		ADDRESS 530 N Carrollton Ave. BALTO, MD. 21223					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4275 cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1/12, 1984, to 1/16, 1984, that (I) (we) last saw the deceased alive on 1/16, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Paula Ehrlich				DEGREE				22c. DATE SIGNED 1/17/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAULA EHRLICH				22e. ADDRESS University of Md Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-23-84		23c. NAME OF CEMETERY OR CREMATORY Harrison Forest Country Club's Mills				23d. LOCATION CITY OR TOWN COUNTY STATE MD.			
24. FUNERAL DIRECTOR NAME William J. Spicer				ADDRESS				25a. DATE REC'D. BY REGISTRAR JAN 20 1984		25b. REGISTRAR'S SIGNATURE John J. [Signature]	

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 2 0

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Sadie Taliaferro Carpenter			MONTH DAY YEAR 1/ 14/1984			M.		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE	7. UNDER 1 YEAR		8. UNDER 24 HRS.	
Female	Black	MONTH DAY YEAR 8 28 1889		94	MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Virginia	U. S. A.			Baltimore City MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	1723 Ashburton Street			Nurse Aide		Seton Institute		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Maryland			Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1723 Ashburton St. Baltimore, Maryland 21216		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Octavia Fleet			Lucinda Tolson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No.			212-28-8151		Ernestine McLain Baltimore, Maryland 21216			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4110 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes 5 yrs 25 + yrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ADVANCED AGE			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-20 , 19 60 , to 1-12 , 19 84 , that (we) last saw the deceased alive on 1-12 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (each) (did not) view the body after death.			
22b. SIGNATURE John J. Chisell, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1/16/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN T. CHISSELL, MD		22e. ADDRESS 9410 W. North Ave. BALTIMORE, MD 21217	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	1/21/1984	First Baptist Church Cem.	Northumberland, Va.
24. FUNERAL DIRECTOR NAME Nutter & Sons 2501 Gwynns Falls		25a. DATE REC'D. BY REGISTRAR JAN 17 1984	
Funeral Home Inc. Pkwy. Baltimore, Md. 21216		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 4 0 0 8 2 1
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Agnes I Carrington			2a. DATE OF DEATH MONTH DAY YEAR 1-11-84		2b. HOUR 2:50 PM
3. SEX F	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 5 3 12		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) - MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unknown	
13a. STATE md.		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2611 Reisterstown Rd. 21217
14. FATHER'S NAME FIRST MIDDLE LAST John Dorsey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Barber		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 577-07-8741		17. INFORMANT ADDRESS Joseph Davis 2035 McCulloh Street			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (c) Infiltrating ductal carcinoma of Left breast 3 yrs ago with radionecrosis left chest wall		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 mins 10 mins
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)		

19a. DATE OF OPERATION 11/1/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Left Breast		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/31 1983 to 1/11 1984 , that (I) (we) lost saw the deceased alive on 1/11 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE B A Collins MD		DEGREE MD		22c. DATE SIGNED 1/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B A Collins MD		22e. ADDRESS 82 S. Greene St. U. of Md. Hosp.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1/17/84	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc. 1101 E North Avenue		25a. DATE REC'D. BY REGISTRAR JAN 13 1984	25b. REGISTRAR'S SIGNATURE John J. Conner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 21 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11/1/83 Carcinoma of Left Breast

BA Collins MD as a friend Hosp
1/1/84
1/1/84
1/1/84

Intubating chest carcinoma of left breast 3 1/2 yrs ago
respiratory arrest
cardiac arrest
10 mins
10 mins

NO 24-4-83

John

Dorsey (Rebecca)

father

md

of Baltimore

x

still hospitalized. and

Baltimore Univ of Md.

unknown

USA - md x

Black 2 1/2

71

Baltimore City

Agnes I Carington

1-11-84 2:50p

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			MONTH DAY YEAR			MONTHS DAYS HOURS MIN.		
EDDIE GLEN CARTER			1 2 84			11:10 ^P _M		
3 SEX			4 RACE			5. DATE OF BIRTH		
Male			Black			MONTH DAY YEAR		
						2 12 21		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			6. AGE (IN YEARS LAST BIRTHDAY)		
Virginia			U.S.A.			62 YRS.		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			9. BALTIMORE CITY OR COUNTY OF DEATH		
BALTIMORE			VAMC BALTIMORE, MARYLAND 21218			BALTIMORE CITY, MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland						Baltimore		
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13d. STREET ADDRESS / ZIP CODE		
FIRST MIDDLE LAST			FIRST MIDDLE LAST			21216		
Gilliam Carter			Beatrice Bland			1150 N. Longwood Street		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. DECEASED ADDRESS		
YES			226 14 8796			Annie Lewis 1220 Bloomingdale Road		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>								9 hours
4280 DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u>								years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):								
<u>Chronic renal failure</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
none						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
			P.M. 19					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION		
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <u>xx</u> (this hospital) attended the deceased from <u>DECEMBER 22</u> , 19 <u>83</u> , to <u>JANUARY 2</u> , 19 <u>84</u> , that <u>(X)</u> (we) lost saw the deceased alive on <u>JANUARY 2</u> , 19 <u>83</u> , and that in <u>xx</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(y)</u> (we) (did) <u>not</u> view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
<u>Mark St. Liwell, MD</u>						1/3/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
<u>Mark St. Liwell, MD</u>			<u>VAMC Baltimore, md 21218</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL			1/9/84		Garrison Forest VA		OWINGS Mills, COUNTY Md.	
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm C March F/H Inc. 1101 E North Avenue					JAN 4 1984		<u>John J. Lewis</u>	

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY



(13)

Fig. 2
P. 100

Longitudinal section
of the fruit

Longitudinal section

x

Root

1912/1

AMC. Baltimore, Md. 21218

Mr. C. C. Smith
Baltimore, Md.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

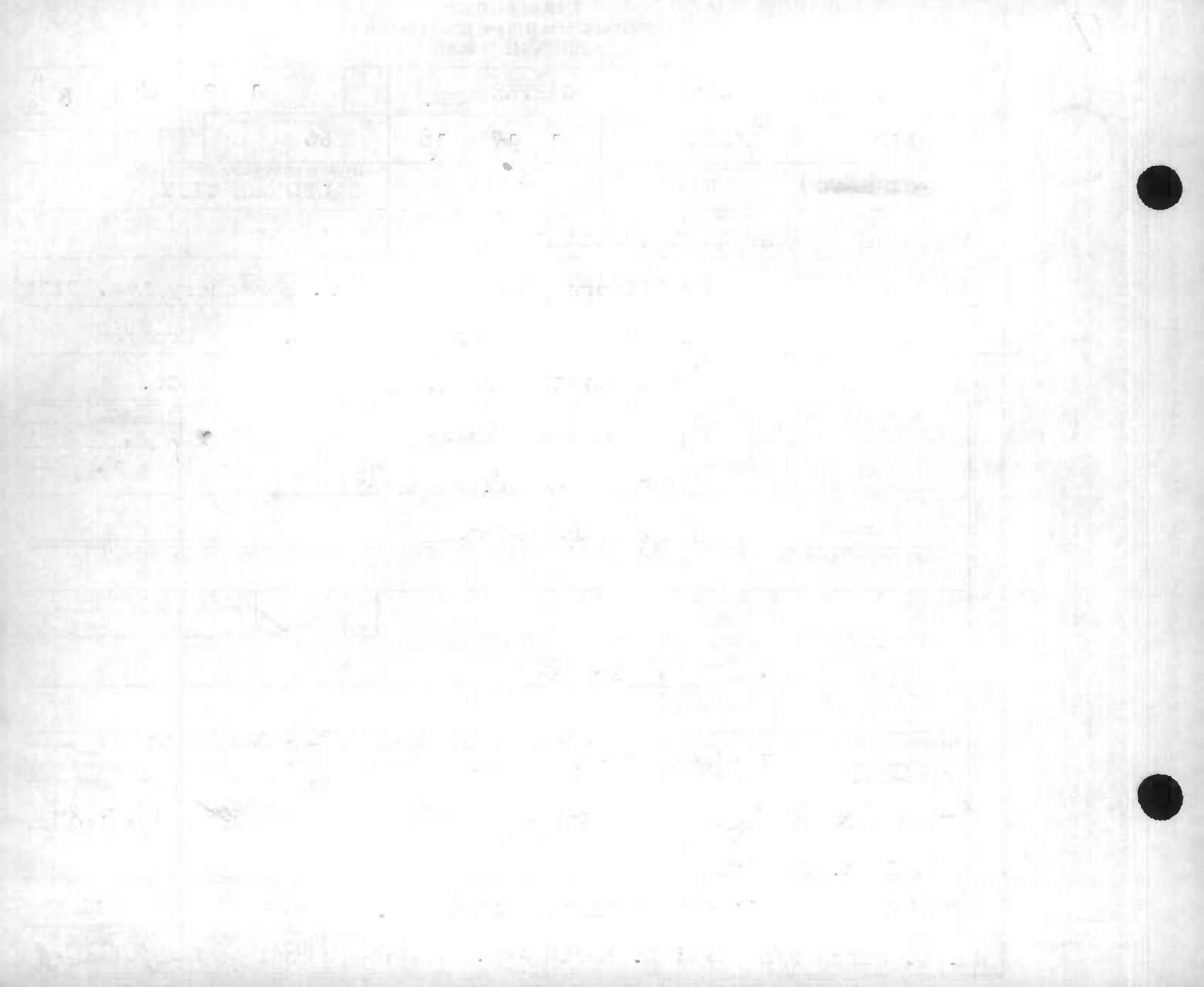
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) HERMAN JAMES CARTER SR.		MONTH 1 DAY 27 YEAR 84		A 8 M	
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH 10 DAY 18	6. AGE (IN YEARS LAST BIRTHDAY) 66	IF UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE COUNTY VA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 68 N. Monastery Ave. 21229
14. FATHER'S NAME FIRST Daniel MIDDLE Carter LAST Carter		15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE E. LAST Croxtan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 227-12-4557		17. INFORMANT ADDRESS Michele Wylie 3 Carissa Ct.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4310 DUE TO, OR AS A CONSEQUENCE OF (b) Intercerebral hemorrhage (R) DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR 8:00 AM <input type="checkbox"/> MONTH 1 DAY 27 YEAR 84 P.M. <input checked="" type="checkbox"/>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 23 Jan. , 19 84 , to 27 Jan. , 19 84 , that (I) (we) lost saw the deceased alive on 27 Jan. , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE David A. Jung		DEGREE MD		22c. DATE SIGNED 1/27/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID A. JUNG MD		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/31/84		23c. NAME OF CEMETERY OR CREMATORY Meadow Ridge Mem.	
23d. LOCATION CITY OR TOWN Laurel		COUNTY MD		STATE	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H		ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JAN 30 1984	
		25b. REGISTRAR'S SIGNATURE John J. Conner			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corresponding Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 2 4

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Jessica A Carter			2a. DATE OF DEATH MONTH DAY YEAR 01/04/84			2b. HOUR 4:59P			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Oct. 21, 1983		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. MONTHS DAYS 02 15		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN. -- --	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. CITY OR TOWN Balti City		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3704 Woodhaven Avenue, 21216	
14. FATHER'S NAME FIRST MIDDLE LAST James L. Carter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adrienne Gezel Bivines			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Adrienne G. Bivines, 3704 Woodhaven Ave.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANOXIA</u> <u>7684</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>PROBABLE SUDDEN INFANT DEATH SYNDROME</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
---	--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/4/84</u> to <u>1/4/84</u> , that (I) (we) last saw the deceased alive on <u>1/4/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>NEAL M. KOTIN</u> DEGREE				22c. DATE SIGNED <u>1/4/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NEAL M. KOTIN				22e. ADDRESS 600 N. Wolfe Street			

23a. BURIAL, CREMATION, REMOVAL SPECIES Burial		23b. DATE 1/7/84		23c. NAME OF CEMETERY OR CREMATORY Eastview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland	
--	--	---------------------	--	---	--	--	--

24. FUNERAL DIRECTOR NAME <u>James E. Fisher</u>		WOODLAWN MEMORIAL HOSPITAL 6111 Windsor Mill Rd. BALTIMORE, MD 21207		25a. DATE REC'D. BY REGISTRAR JAN 11 1984		25b. REGISTRAR'S SIGNATURE <u>John J. Gail</u>	
--	--	---	--	--	--	---	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove the pages marked "F" and "D" and file them within 72 hours after death.

Released on approval By Dr. Michael Smyth/Pet. Mr. Freeman

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS

1900
1910
1920
1930
1940
1950
1960
1970
1980
1990
2000
2010
2020

1900
1910
1920
1930
1940
1950
1960
1970
1980
1990
2000
2010
2020

1900
1910
1920
1930
1940
1950
1960
1970
1980
1990
2000
2010
2020

1900
1910
1920
1930
1940
1950
1960
1970
1980
1990
2000
2010
2020

1900
1910
1920
1930
1940
1950
1960
1970
1980
1990
2000
2010
2020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked **exempt**, 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST <i>Katherine</i> MIDDLE <i>Grace</i> LAST <i>Carter</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>1/31/84</i>			2b. HOUR <i>12:15</i> M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 13, 1895</i>		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOME CORP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Canterbury Road Ambassador Apts. 26218	
14. FATHER'S NAME FIRST MIDDLE LAST George Fremont Clark					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Getzandanner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-22-4549		17. INFORMANT Son: ADDRESS C. Read Carter, 3900 N. Charles St. 21218					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> <i>1560</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Adenocarcinoma of Gallbladder</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____									
19a. DATE OF OPERATION <i>10/28/83</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Abdominal Pain and Jaundice</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>6/2</i> 19 <i>77</i> to <i>1/31</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>1/31</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Lawrence J. Appel</i>					DEGREE		22c. DATE SIGNED <i>1/31/84</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lawrence J. Appel</i>					22e. ADDRESS <i>Church Home Hospital</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE <i>2/1/1984</i>		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD			
24. FUNERAL DIRECTOR NAME STEWART & MOWEN CO., 108 W. North Ave. 21201					25a. DATE REC'D BY REGISTRAR FEB 3 1984		25b. REGISTRAR'S SIGNATURE <i>John J. [Signature]</i>		

BP

1

WILLIAM BOWEN

James

Levyman

Baltimore

Portland

George

no

John

...

De-Lin...

Francis

314-51-0330

Jan. 11, 1932

Baltimore City

Home

Chapman Bond

Insurance Agent

Georgetown

Box:

314-51-0330, 3900 N. Charles St., 3111

WILLIAM

...

Green House Laundry, Baltimore

WILLIAM BOWEN, 106 N. North Ave., 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 2 6

1- FOR
STATE
REGISTRAR

REG. NO.

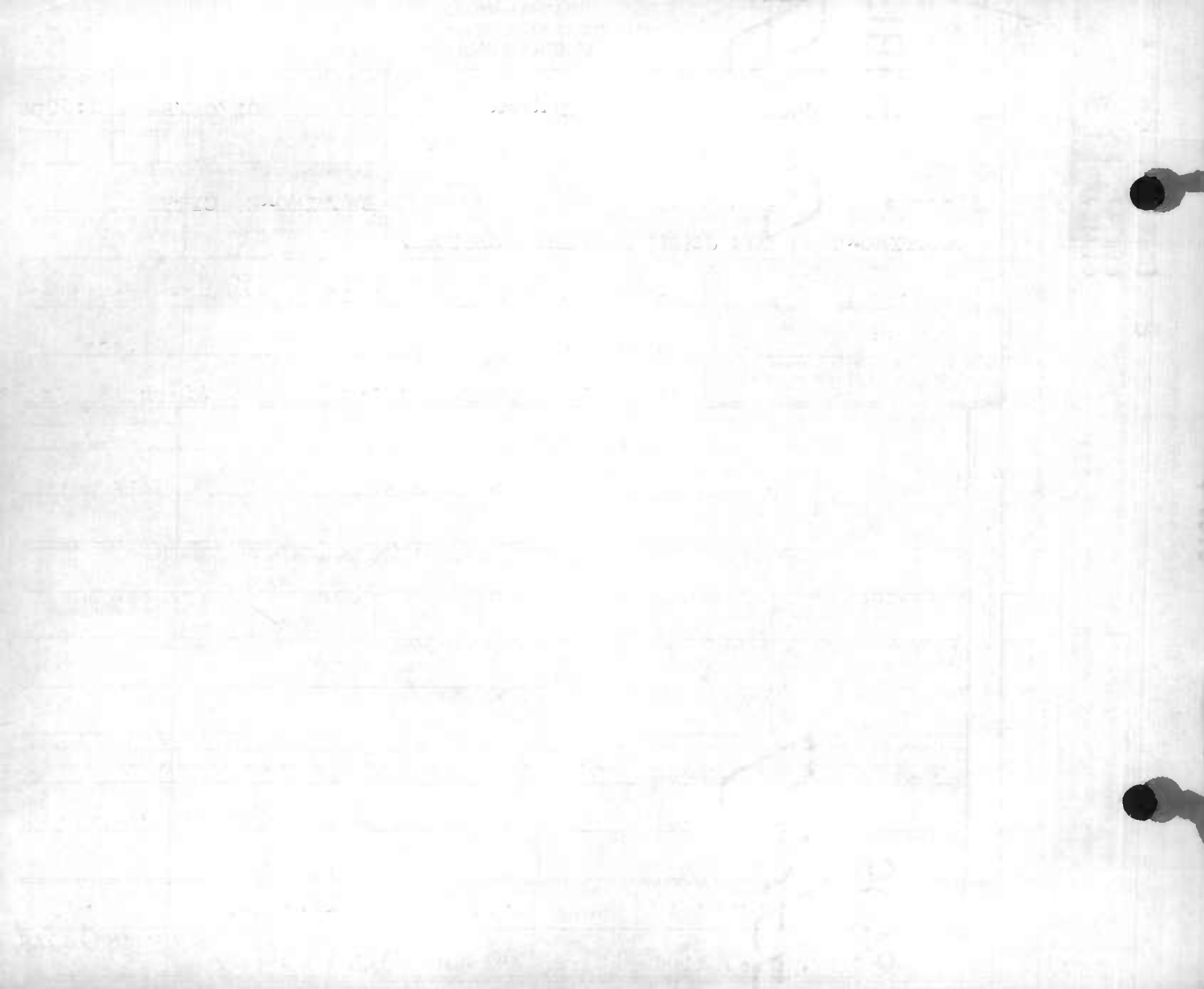
1 DECEASED NAME (TYPE OR PRINT) NOAH			2a DATE OF DEATH MONTH DAY YEAR 01/08/84			2b HOUR 8:50pm				
1 SEX Male		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4 11 97		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN. 86		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE Maryland			13b COUNTY		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 1232 N. Aisquith St. 21202	
14. FATHER'S NAME FIRST MIDDLE LAST Willie Carter			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delia Carter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. 420-05-8269		17 INFORMANT ADDRESS Lantha Carter 1232 N. Aisquith Street					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 0384 DUE TO, OR AS A CONSEQUENCE OF (b) GRAM NEGATIVE SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 50 minutes 20 hours		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IE EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from January 7, 1984 , to January 8, 1984 , that (I) (we) last saw the deceased alive on January 8, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Kara L. Riley MD			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 1/8/84		
22d PHYSICIAN'S NAME (TYPE OR PRINT) KARA L RILEY MD			22e ADDRESS JOHNS HOPKINS HOSPITAL							
23a BURIAL, CREMATION, REMOVAL (TYPE) BURIAL			23b DATE 1/13/84		23c NAME OF CEMETERY OR CREMATORY Mount Auburn Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24 FUNERAL DIRECTOR NAME Wm C March F/H Inc, 1101 E North Avenue					25a DATE REC'D. BY REGISTRAR JAN 11 1984		25b REGISTRAR'S SIGNATURE John J. Carter			

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR 10 YEARS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO. 00827					
1- FOR STATE REGISTRAR MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED NAME (TYPE OR PRINT)			FIRST Sultan			MIDDLE Carter			LAST Sr.			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 1/8/84 19		2b. HOUR M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 15 20		6. AGE (IN YEARS) (LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 1/8/84 19		2d. HOUR 1:42 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1705 N. Wolfe St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21213 1705 N. Wolfe Street					
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 247-26-7939A		17. INFORMANT ADDRESS Aaron Carter 1705 N. Wolfe Street									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> 1991 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion TITLE (SPECIFY) M.D. Deputy Chief DATE SIGNED 1/9/84															
ACTUAL SIGNATURE Thomas D. Smith, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201											
23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL				23b. DATE 1/13/84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA				23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills, Md.					
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. ADDRESS 1101 E North Avenue						25a. DATE REC'D. BY REGISTRAR JAN 9 1984		25b. REGISTRAR'S SIGNATURE John J. Conner							



UNIT 1

7-17-1940

WIA



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHM-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRATION AKA Estella Cartledge CERTIFICATE OF DEATH									
REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) ESTELLA CARTLEDGE					2a. DATE OF DEATH MONTH DAY YEAR 1/10/84 2b. HOUR 6:46 AM				
3 SEX F female		4 RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR July 1, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CITY MD.			
10 CITY OR TOWN OF DEATH Baltimore Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE D.C.		13b. COUNTY D.C.		13c. CITY OR TOWN Washington, D.C.		13d. INSIDE CITY LIMITS? Yes		13e. STREET ADDRESS 4671 Benning Rd. S.E. Apt. 99999	
14 FATHER'S NAME FIRST MIDDLE LAST David No Middle Hammond					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Hammond				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. Unavailable		17. INFORMANT 4671 Benning Road, S.E. Apt. A David Blakeney, Son		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. 5522 IMMEDIATE CAUSE (a) Cardiac arrest									
DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure									
DUE TO, OR AS A CONSEQUENCE OF (c) Multiorgan failure									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None									
19a. DATE OF OPERATION 12/23 - 12/27		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Debridement of Decubitus Ulcer				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/23/80 , to 1/10/84 , that (I) (we) last saw the deceased alive on 1/10/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (do) not view the body after death.)									
22b. SIGNATURE [Signature] DEGREE					22c. DATE SIGNED 1/10/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PELAYO E CORREA					22e. ADDRESS LUTHERAN HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE January 14, 1984		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Landover		23d. LOCATION CITY OR TOWN COUNTY STATE Prince Georges Cou. Md.			
24. FUNERAL DIRECTOR W. James Bacon Funeral Home Inc., 3447-14th St. N.W.					25a. DATE REC'D BY REGISTRAR JAN 17 1984 25b. REGISTRAR'S SIGNATURE [Signature]				

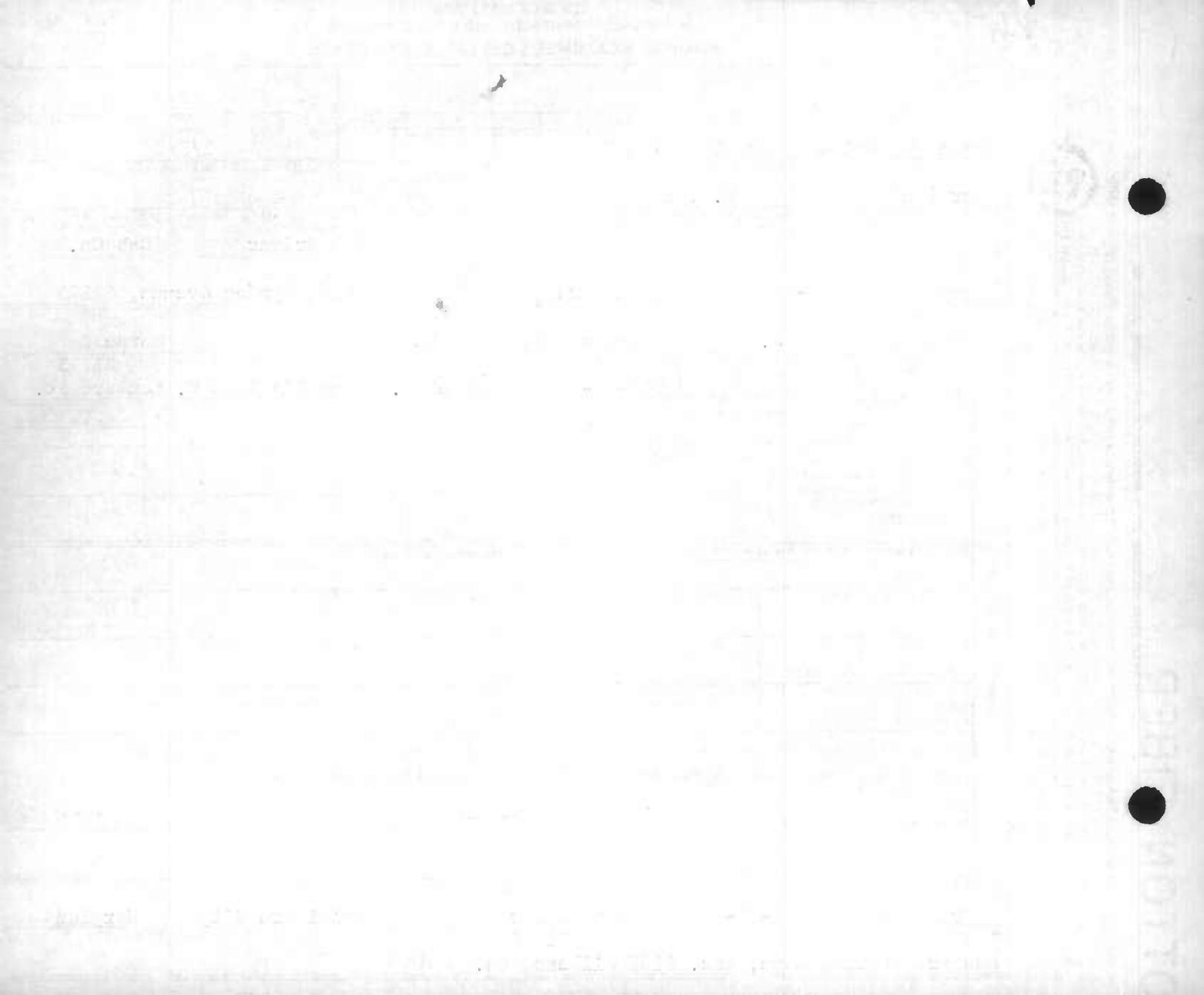




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Paul J. Casper										2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 1/5/84 19		2b. HOUR AM PM 4:26 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 09 28 47		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 36	IF UNDER 1 YR. MONTHS DAYS HOURS MIN 36		IF UNDER 24 HRS. HOURS MIN 36		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1/5/84 19		2d. HOUR AM PM 4:26 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4500 Blk. Clifton Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cab driver		12b. KIND OF BUSINESS OR INDUSTRY Cab Co.				
13a. STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1256 Glyndon Avenue, 21223				
14. FATHER'S NAME FIRST MIDDLE LAST Paul J. Casper Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel Werness								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-44-5004		17. INFORMANT ADDRESS Hazel M. Buscaglia 1830 W. Lombard St. 21223						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shotgun wound to the head</u> 9651 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 4:20 AM 1/5/84				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:20 AM 1/5/84				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot				
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Taxicab				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4500 Clifton Ave., Balto City Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>						TITLE (SPECIFY) Assistant			DATE SIGNED 1/5/83			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.						ADDRESS 111 Penn St., Balto., Md. 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 01-07-84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland		
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.						25a. DATE REC'D. BY REGISTRAR JAN 9 1984		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 4 0 0 8 3 0	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		
FIRST MIDDLE LAST GEORGE C. CAVEY			MONTH DAY YEAR 01 18 84	2b. HOUR 4:42 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE	WHITE	MONTH DAY YEAR 12 29 13		70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND	U.S.A.			BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
BALTIMORE		ST. AGNES HOSPITAL E.R.		INSPECTOR	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE			
AUTOMOBILE		1918 GRINNALDS AVENUE, 21230			
13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		---		BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
JOSEPH ALBERT CAVEY		SOPHIE MAY RAFF			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		216-01-8099		ELIZABETH HELEN CAVEY 1918 GRINNALDS AVE. 21230	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>M.I.</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>H. A.S.H.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>August 16</u> , 19 <u>74</u> , to <u>September 20</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>September 30</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE <u>NEVZAT TURKMAN</u> DEGREE		22c. DATE SIGNED 1-19-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
NEVZAT TURKMAN, M.D.		2601 WASHINGTON BOULEVARD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		01-21-84		LOUDON PARK	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
HUBBARD FUNERAL HOME, INC.		4107 WILKENS AVE.		JAN 23 1984	
25b. REGISTRAR'S SIGNATURE					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked on item 15, any injury, or other traumatic event, the medical examiner must be notified at once.)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 3 1

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Isidoros N. Cederakis			2a. DATE OF DEATH MONTH DAY YEAR 01/07/84			2b. HOUR 8:22 PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 9 98		6. AGE (IN YEARS LAST BIRTHDAY) 86		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Restaurateur			12b. KIND OF BUSINESS OR INDUSTRY Food		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 520 N. Bouldin Street 21205	
14. FATHER'S NAME FIRST MIDDLE LAST Nicholas Cederakis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Steliani							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 083-03-0752A		17. INFORMANT ADDRESS Mrs. Oreanthe Cederakis, 520 N. Bouldin St. Baltimore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1533 IMMEDIATE CAUSE (a) Hemorrhagic shock. DUE TO, OR AS A CONSEQUENCE OF (b) Rupture of sigmoid colon DUE TO, OR AS A CONSEQUENCE OF (c) CA of sigmoid									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).										
19a. DATE OF OPERATION 1/7/83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Aneurysm			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/17/82 to 1/7/84, that (I) (we) lost saw the deceased alive on 1/7/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE A. Saroi			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 1/7/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS St. Agnes Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-10-84		23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.		
24. FUNERAL DIRECTOR Nicholas T. Matthews, 3021 Eastern Avenue Baltimore, Md.					25a. DATE REC'D. BY REGISTRAR JAN 10 1984			25b. REGISTRAR'S SIGNATURE John J. Carver		

BP

INDEX

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

Item 6, G-591, 5/9/84, by F.H., Gbj. STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 4 0 0 8 3 2

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lee Central			2a. DATE OF DEATH MONTH DAY YEAR 1-17-1984			2b. HOUR 7:20 P.M.				
3. SEX Male		4. RACE BLK		5. DATE OF BIRTH MONTH DAY YEAR 11 13 35		6. AGE (IN YEARS LAST BIRTHDAY) 44 48 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2826 Windsor Avenue 21216	
14. FATHER'S NAME FIRST MIDDLE LAST Leo Central			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Lee Canty							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 251-56-2210			17. INFORMANT ADDRESS Elnora Central 2826 Windsor Avenue				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART 1. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Cardiopulmonary Arrest**
1629
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
 (b) **Terminal carcinoma of the lung**
 (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?
YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **1-17-84** to **1-17-84**, that (I) (we) lost saw the deceased alive on **1-17-84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE
A. Vento, M.D.
DEGREE
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED
1-17-1984

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. Vento

22e. ADDRESS
Lutheran Hospital, Baltimore, MD

23a. BURIAL, CREMATION, REMOVAL
BURIAL

23b. DATE
1/21/84

23c. NAME OF CEMETERY OR CREMATORY
Mount Auburn Cem.

23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md.

24. FUNERAL DIRECTOR
NAME ADDRESS
William C March F/H Inc. 1101 E North Avenue

25a. DATE RECEIVED BY REGISTRAR
JAN 19 1984

25b. REGISTRAR'S SIGNATURE
John J. Carver

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

BP

1

100-100000

100-100000

100-100000



100-100000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 3 3

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANK XXX CHAIET			2a. DATE OF DEATH MONTH DAY YEAR 1-2-84			2b. HOUR 4:05 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 04-18-1908		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S. (N.Y.)		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Levinson Hebrew Geriatric Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHAUFFEUR	
12b. KIND OF BUSINESS OR INDUSTRY TAXIS		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 704 S. Sudbrook Rd. Md 21208	
14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM CHAYET				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ZWIEBACH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-14-9094		17. INFORMANT MRS. CYNTHIA KUPERMAN 704 SUDBROOK RD. BALTO., MD 21208			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure. 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(b) ASCD with Atrial Fibrillation.			
(c) Urinary Tract Infection.			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Urinary Tract Infection.**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-22- 19 82 to 1-2- 19 84 , that (I) (we) last saw the deceased alive on 12-22- 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE SET H T W A R				DEGREE LEVINSON		22c. DATE SIGNED 1-2-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SET H T W A R				22e. ADDRESS LEVINSON			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 3, 1984		23c. NAME OF CEMETERY OR CREMATORY PETACH TIKVAH		23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD	
--	--	----------------------------------	--	--	--	---	--

24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERS TOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR JAN 5 1984		25b. REGISTRAR'S SIGNATURE John J. Connel	
--	--	--	--	--	--	---	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

20% COLLOID

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8 4 0 0 3 3 4							
1. DECEASED NAME (TYPE OR PRINT)			FIRST WILLIAM	MIDDLE R.	LAST CHALK	2b. DATE OF DEATH MONTH DAY YEAR January 23, 84			2b. HOUR 5:48a M
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 17 1897		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTO MD 21218				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3424 Keswick Road 21211	
14. FATHER'S NAME FIRST MIDDLE LAST William Robert Chalk			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie (unknown)			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			
16b. SOCIAL SECURITY NO. WW 1			17. INFORMANT ADDRESS 21211			Mr. William R. Chalk, Jr. 702 W. 33rd. St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 2765 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>40 minutes</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Dehydration, starvation, urinary tract infection</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Dec 27</u> , 19 <u>83</u> , to <u>January 23</u> , 19 <u>84</u> , that (I) (we) lost <u>the deceased alive on</u> <u>January 23</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE <u>R. J. Seitz</u>				DEGREE MD				22c. DATE SIGNED 1/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>R. J. Seitz</u>				22e. ADDRESS 3900 Loch Raven Blvd. Balto Md 21218					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/26/84		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS A. Alan Seitz, Jr. 3818 Roland Ave. 21211									

11 DEC

11 DEC

011

11 DEC 1968

Item 13a.b.c.d. for per ph. 1/26/84

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

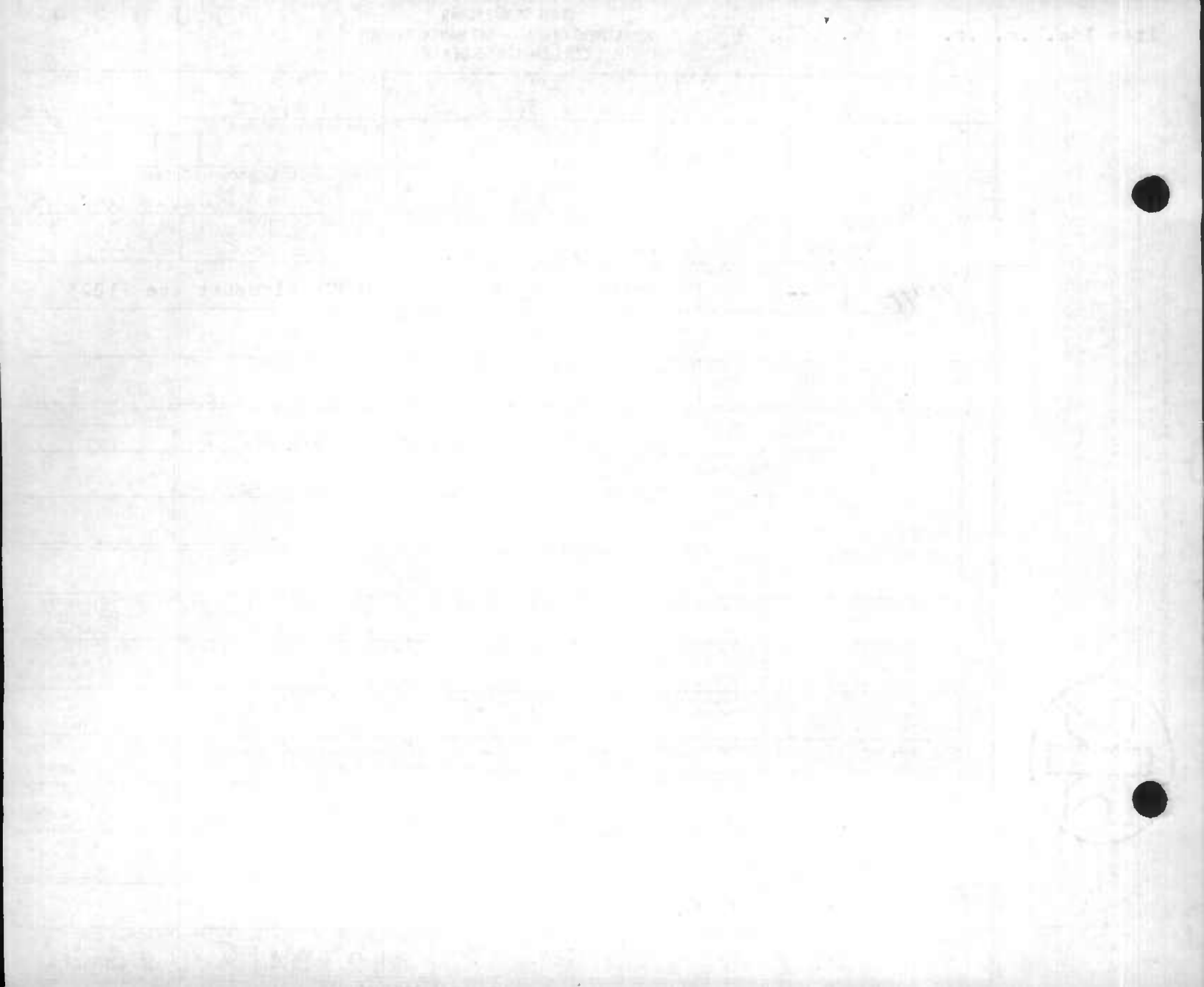
1. DECEASED NAME (TYPE OR PRINT) BABY BOY CHANCE			2a. DATE OF DEATH MONTH DAY YEAR 1/13/84			2b. HOUR 10:25 PM			
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 13 84		6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS.		IF UNDER 1 YEAR MONTHS DAYS 2 55	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? —		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) U Md Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fetus		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. STATE MD		13b. COUNTY —		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. STREET ADDRESS 1040 Fairmount Ave 21223					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST 7650 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) EXTREME PREMATURITY DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/13 , 19 84 , to 1/13 , 19 84 , that (I) (we) lost saw the deceased alive on 1/13 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Elizabeth Francis			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 1/14/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELIZABETH FRANCIS MD			22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 1/19/84		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board					ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR IAN 23 1984		25b. REGISTRAR'S SIGNATURE John J. Connel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) BELLANT M CHANCE					2a. DATE OF DEATH MONTH DAY YEAR 1/22/84			2b. HOUR 12:30 PM	
3. SEX Female		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 11 26 19		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (IF NOT BORN IN MARYLAND) DELAWARE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE MARYLAND		13b. COUNTY KENT		13c. CITY OR TOWN GALENA		13e. STREET ADDRESS BOX 84 21635 MD. RT 213			
14. FATHER'S NAME FIRST MIDDLE LAST FLOYD RANSON					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY COX				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no					16b. SOCIAL SECURITY NO. 222-05-3104		17. INFORMANT ADDRESS THOMAS CHANCE husband same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PERFORATED PEPTIC ULCER DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF THE UTERUS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 minutes 9 days MANY MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/27 1983 to 1/22 1984 , that (I) (we) last saw the deceased alive on 1/22/84 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James A. D. [Signature]								22c. DATE SIGNED 1/22/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAMASCHUS					22e. ADDRESS 22 S. GREEN ST. 21201				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/26/84		23c. NAME OF CEMETERY OR CREMATORY Galena Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Galena kent MD			
24. FUNERAL DIRECTOR NAME EDW. FELLOWS & SON MILLINGTON, MD 21635					25a. DATE REC'D. BY REGISTRAR JAN 30 1984				
25b. REGISTRAR'S SIGNATURE John J. Connel									

BP

U.S. DEPARTMENT OF THE ARMY
HEADQUARTERS
WASHINGTON, D.C.

76

RECEIVED

OFFICE OF THE ADJUTANT GENERAL

FILED

206000 11 2



ADJUTANT GENERAL
WASHINGTON, D.C.
1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 4 0 0 8 3 7				
REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) ARCHIE CHANDLER				2a. DATE OF DEATH MONTH 01 DAY 05 YEAR 84				2b. HOUR 3:47 PM
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH 12 DAY 29 YEAR 1898		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) N.C.	7b. CITIZEN OF WHAT COUNTRY? yes		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PROVIDENT HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE M.D.	13b. COUNTY Balto	13c. CITY OR TOWN Balto	13e. STREET ADDRESS 2216 Ruskin Ave 21217					
14. FATHER'S NAME FIRST John MIDDLE Chandler LAST Chandler		15. MOTHER'S MAIDEN NAME FIRST Alice MIDDLE Bayl LAST Bayl						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Mrs Eunice Ghee - 2216 Ruskin St				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 4292 DUE TO, OR AS A CONSEQUENCE OF (b) GANGLIENE LOWER EXTREMITIES, ASCV DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 11/29 , 19 83 , to 01/05 , 19 84 , that (I) (we) lost saw the deceased alive on 01/05 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Emeka Okeke, MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 01/05/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EMEKA OKEKE				22e. ADDRESS 2600 LIBERTY HTS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/6/84		23c. NAME OF CEMETERY OR CREMATORY Charch Cem		23d. LOCATION CITY OR TOWN Kilmarick COUNTY STATE PA.		
24. FUNERAL DIRECTOR NAME BAINES ADDRESS 1348 N CHANNON ST				25a. DATE REC'D. BY REGISTRAR JAN 11 1984		25b. REGISTRAR'S SIGNATURE John J. Conner		

BP. _____

UNITED STATES DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF STAFF
WASHINGTON, D. C.

MEMO

TO: THE CHIEF OF STAFF
FROM: THE CHIEF OF STAFF
SUBJECT: [Illegible]

CHIEF OF STAFF

2006 EDITION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 3 8

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ambrose Perry Chaney</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>January 24, 1984</i>		2b. HOUR <i>1:00 PM</i>		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>6/13/1923</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <i>60</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>S. Baltimore General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Burner</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Bethlehem Steel</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>---</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joseph Chaney</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Laura Chaney</i>		13e. STREET ADDRESS <i>1512 Sycamore St.,</i>		21226	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>218-12-9305</i>		17. INFORMANT <i>Mary G. Chaney</i>		ADDRESS <i>Same as #13</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

4100

IMMEDIATE CAUSE (a) *Myocardial Infarction*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) *Atherosclerosis*

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Diabetes Mellitus; Previous Myocardial Infarction

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from *19* to *19* that (I) (we) lost
saw the deceased alive on *19* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <i>Richard E. Fisher</i>		DEGREE		22c. DATE SIGNED <i>26 Feb. 84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Richard E. Fisher</i>		22e. ADDRESS <i>4700 Pennington Ave</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1/27/1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Pk.</i>		23d. LOCATION (STREET OR HIGHWAY) CITY OR TOWN COUNTY STATE <i>Glen Burnie, A. A. Co., Md.</i>	
24. FUNERAL DIRECTOR NAME <i>McCully Funeral Homes</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 30 1984</i>		25b. REGISTRAR'S SIGNATURE <i>2</i>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7-15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

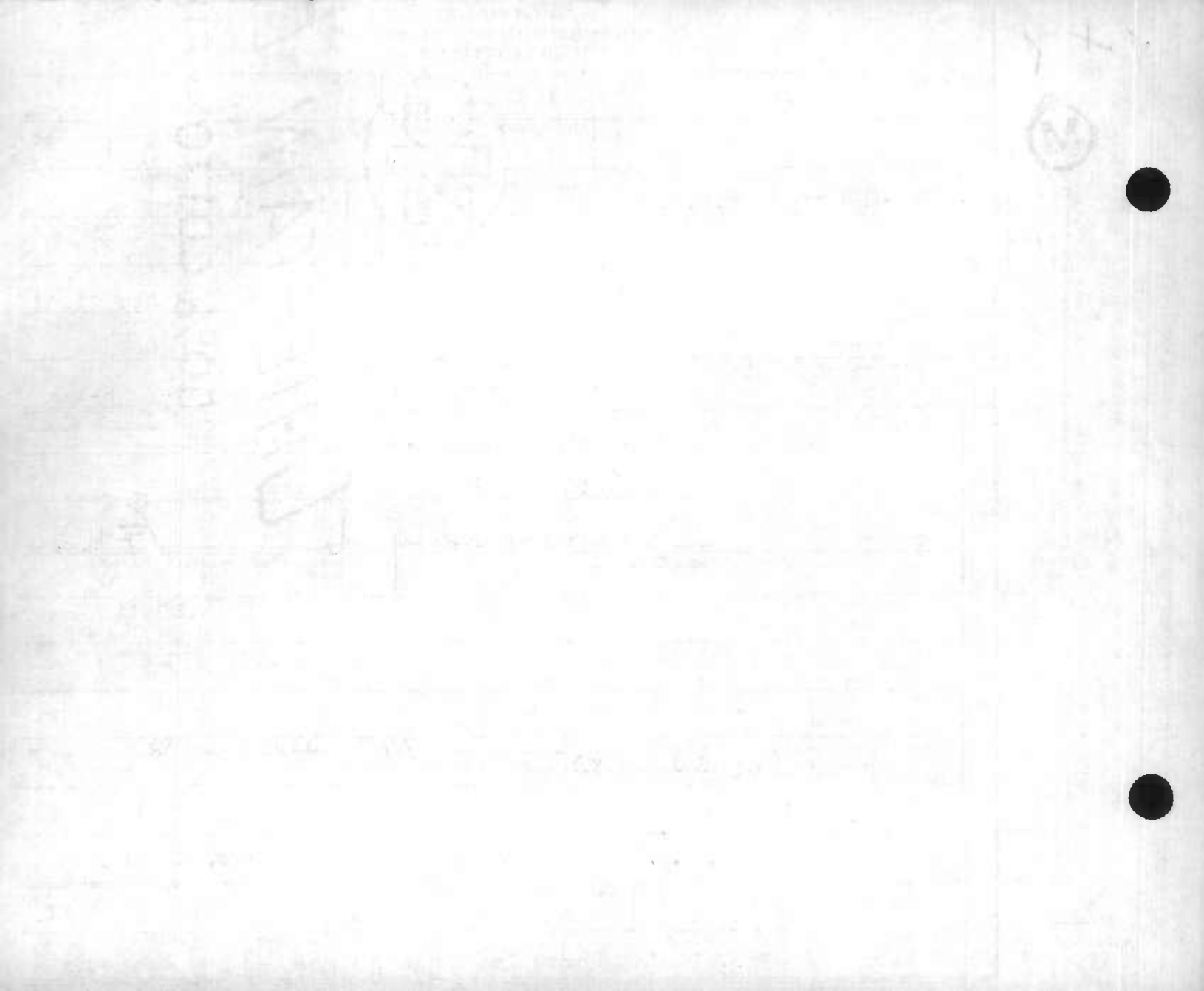
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 84 000339				
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR HOUR				
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BENJAMIN CHASE JR.					1 1 84 M				
3 SEX Male		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 25 13		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13e. STREET ADDRESS 1001 West 43rd St. 21211			
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Chase					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mable Goings				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					16b. SOCIAL SECURITY NO. 218-07-7656		17. INFORMANT ADDRESS Nellie Chase 1001 West 43rd Street		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute M.I.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery dis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 yrs</u>								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>9 yrs</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 30</u> , 19 <u>83</u> , to <u>Dec</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Dec 30</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>M. N. Ch</u> DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/3/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Myung Hee Chung, M.D.					22e. ADDRESS 5670 The Alameda Baltimore, MD 21239				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/4/84		23c. NAME OF CEMETERY OR CREMATORY Mount Calvary Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md.			
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue					25a. DATE REC'D. BY REGISTRAR JAN 4 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JOSEPH FRANKLIN (FRANCIS) CHASE			2a. DATE OF DEATH MONTH DAY YEAR 01 17 84			2b. HOUR 12:00AM					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11/ 28 /1916		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO., MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, BALTIMORE, MARYLAND 21218				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECURITY GUARD		12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL			
13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 332 S. CLINTON STREET 21224		
14. FATHER'S NAME FIRST MIDDLE LAST WALTER CHASE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATIE KOIVAC							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. W.W. II 218.01.9968		17. INFORMANT BESSIE B. CHASE				ADDRESS SAME AS 13e.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulm Cessation</u> <u>5739</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>End Stage Liver Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH >1yr		
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/27 , 19 83 , to 01-17 , 19 84 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 01-17 , 19 84 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.									22c. DATE SIGNED 1/17/84		
22b. SIGNATURE M. G. Meyer			22e. ADDRESS 3900 LOCH RAVEN BLVD. BALTIMORE, MD. 21218								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry Ohleyer			22f. ADDRESS 3900 LOCH RAVEN BLVD. BALTIMORE, MD. 21218								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 1/18/1984		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND				
24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222			25a. DATE REC'D BY REGISTRAR JAN 18 1984		25b. REGISTRAR'S SIGNATURE John J. Lohr						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN COPIES OF YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE KNOWN OF DEATH		2b. HOUR	
Thomas Chase, Jr.				E.				DATE KNOWN OF DEATH		1 16 19 84	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		7b. HOUR	
Male		Black		March 17, '64		19 YRS.		MONTHS DAYS HOURS MIN.		11:30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland				United States						Baltimore City, MD.	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore				2601 Wilkens Avenue							
13a. STATE										13b. CITY OR TOWN	
Maryland										Charles Belton	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				13d. INSIDE CITY LIMITS?			
Thomas E. Chase Sr.				Emma A. Thomas				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
No				Unknown				Thomas E. Chase Sr. Belton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9654 IMMEDIATE CAUSE (a) Gunshot wound to head Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
11:15 AM				1 16 1984				Subject shot			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
				bar				2601 Wilkens Ave. Balto. Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Thomas D. Smith, M.D.				Deputy Chief				1/17/84			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Thomas D. Smith, M.D.				111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial				Jan. 20, 1984		St. Ignatius		Chapel Point Charles Md.			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR			
Thornton Funeral Home				Pomonkey, Md.				25b. REGISTRAR'S SIGNATURE			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) TISSUER		2a. DATE OF DEATH MONTH DAY YEAR JAN 28, 1984		2b. HOUR 10:45 AM	
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 09 21 16		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balt MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD.	
10. CITY OR TOWN OF DEATH BALT	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinar Hosp of Balt		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY BALT	13c. CITY OR TOWN BALT	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Jeffries		16. STREET ADDRESS 3805 WOODBINE AVE 21207	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS B Greene 2526 Calverton Hgts	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Encephalopathy 1991 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Adenocarcinoma DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JAN 4 19 84 , to JAN 28 19 84 , that (I) (we) <input checked="" type="checkbox"/> saw the deceased alive on JAN 28 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert De Marco, MD		DEGREE		22c. DATE SIGNED 1-28-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT DE MARCO, MD		22e. ADDRESS Sinar Hosp of Balt.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-1-84		23c. NAME OF CEMETERY OR CREMATORY MT. ZION	
23d. LOCATION (CITY OR TOWN) COUNTY STATE BALTO Md.		24. FUNERAL DIRECTOR NAME Jas. A. Morton & Sons		25a. DATE REC'D. BY REGISTRAR JAN 31 1984	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. ADDRESS 1701 LAURENS			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

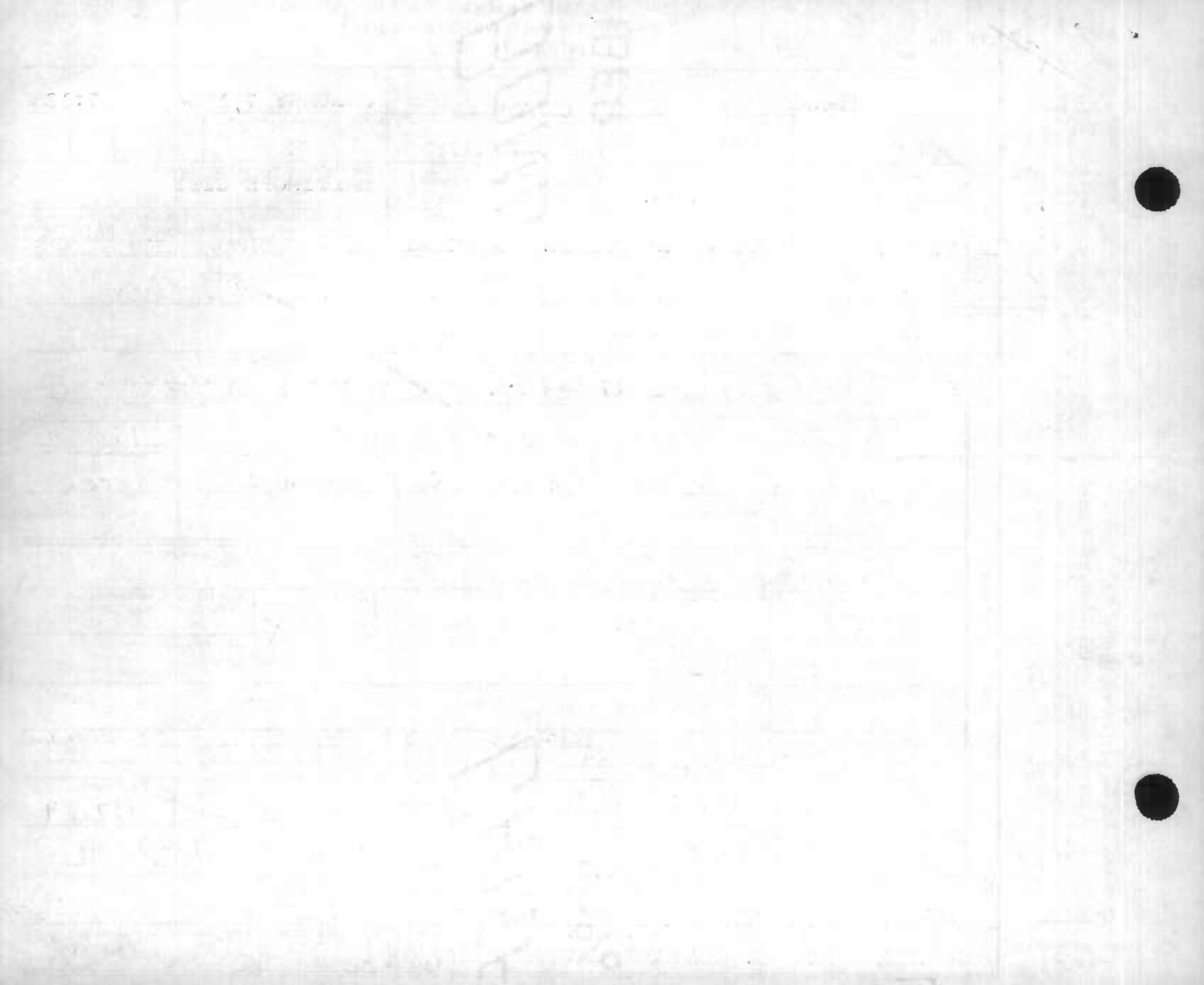
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

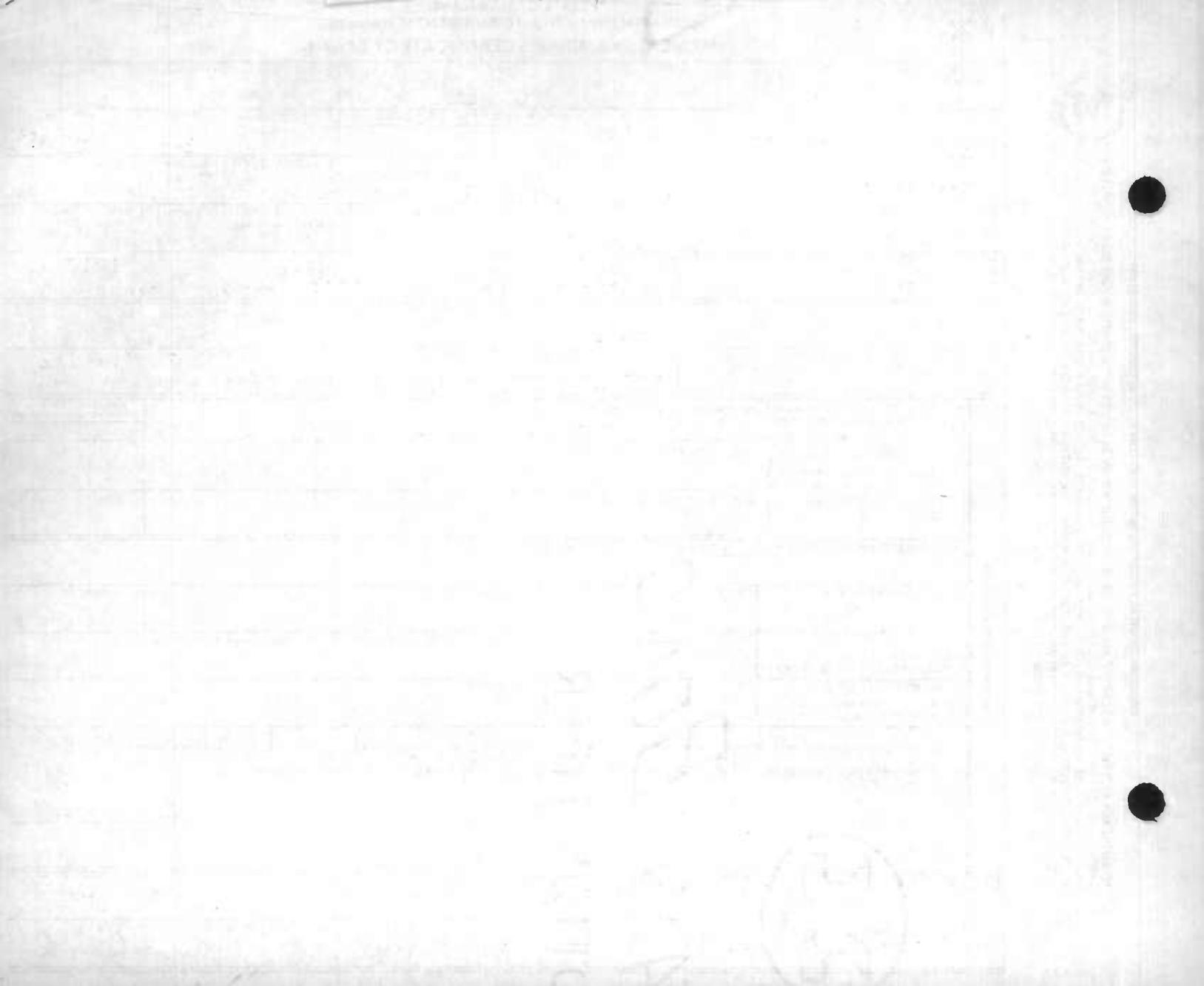
1. DECEASED NAME (TYPE OR PRINT) HARRY			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 7, 1984			2b. HOUR 7:13A					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 6, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) VICE-PRINCIPAL		12b. KIND OF BUSINESS OR INDUSTRY BALTIMORE CITY SCHOOLS			
13a. STATE MARYLAND		13b. CITY OR TOWN BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST ISAAC		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH		13e. STREET ADDRESS / ZIP CODE 3507 MELODY LANE 21207							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII Army 212-22-5449		17. INFORMANT ADDRESS MRS. ANN CHAYT 3507 MELODY LANE 21207							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4130 IMMEDIATE CAUSE (a) Cardio pulmonary Arrest. DUE TO, OR AS A CONSEQUENCE OF (b) renal failure AND pneumonia. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Coronary artery Disease.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 week			
19a. DATE OF OPERATION 12/30/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Unstable Angina		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTE BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12/22/83 , 19 83 , to 1/7 , 19 84 , that (I) (we) (we) last saw the deceased alive on 1/7 , 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								22b. SIGNATURE Charles D. Cousar DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/7/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.D. COUSAR				22e. ADDRESS JOHNS HOPKINS HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/8/84		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH CEM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215						25a. DATE REC'D. BY REGISTRAR JAN 10 1984		25b. REGISTRAR'S SIGNATURE John J. Connel			



REG. NO.

MEDICAL CERTIFICATION

20M 4/B2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, it shows any injury, or other traumatic event, the medical investigation should be conducted in order to determine the cause of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 4 0 0 8 4 5							
1. DECEASED NAME (TYPE OR PRINT) POCANDA Margaret CHRISTIAN					2a. DATE OF DEATH MONTH DAY YEAR 01 26 84					2b. HOUR 8:30 PM		
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 20, 1920		6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.						
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13e. STREET ADDRESS 3540 Elmora Ave 21213						
14. FATHER'S NAME FIRST MIDDLE LAST Carmello Bellestri					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Maggiore							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 219-20-5792		17. INFORMANT Mr Walter G Christian			ADDRESS Same As 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Squamous cell carcinoma of the lung 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 01-08-1984 to 01-26-1984 , that (I) (we) last saw the deceased alive on 01-26-1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE A. Sergio Cassanego MD				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 01-26-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. SERGIO CASSANEGO				22e. ADDRESS 5601 LOCH RAVEN BLVD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/30/84		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Juan J. Caniel						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copiers. Pages 1 and 2 should be filed with the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR Item 21b thru 22a STATE 2-27-84 cn REGISTRAR					8 4 0 0 8 4 6 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Andrew ANTHONY CICHOWICZ					2a. DATE OF DEATH MONTH DAY YEAR JANUARY 28, 1984					
3. SEX Male					4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 19, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Shipyard		12b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		
13a. STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 702 S. Lakewood Ave., 21224		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Cichowicz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Puivalski						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 195-05-0660		17. INFORMANT ADDRESS Raymond N. Fennell 3709 Third St., Balto., 21225				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA 5070 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: EPIDURAL HEMATOMA INTERTROCHANTERIC FRACTURE OF RIGHT HIP HYPERTENSION										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. YES IF FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10-23 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) SUBJECT FELL ACCIDENT					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) at home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Baltimore Md					
22. I certify that (I) (this [initials]) attended the deceased from JANUARY 28 1984 to JANUARY 28 1984 that (I) (we) last saw the deceased alive on JANUARY 28 1984 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22a. SIGNATURE John R. Bartholomew					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/28/84	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN BARTHOLOMEW					22e. ADDRESS CHURCH HOSPITAL 100 NORTH BROADWAY 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/31/1984		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Essex, Balto., Md.		
24. FUNERAL DIRECTOR NAME McCully Funeral Homes					25a. DATE REC'D. BY REGISTRAR JAN 30 1984		25b. REGISTRAR'S SIGNATURE [Signature]			

BP-533



RECEIVED



[Faint, mostly illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

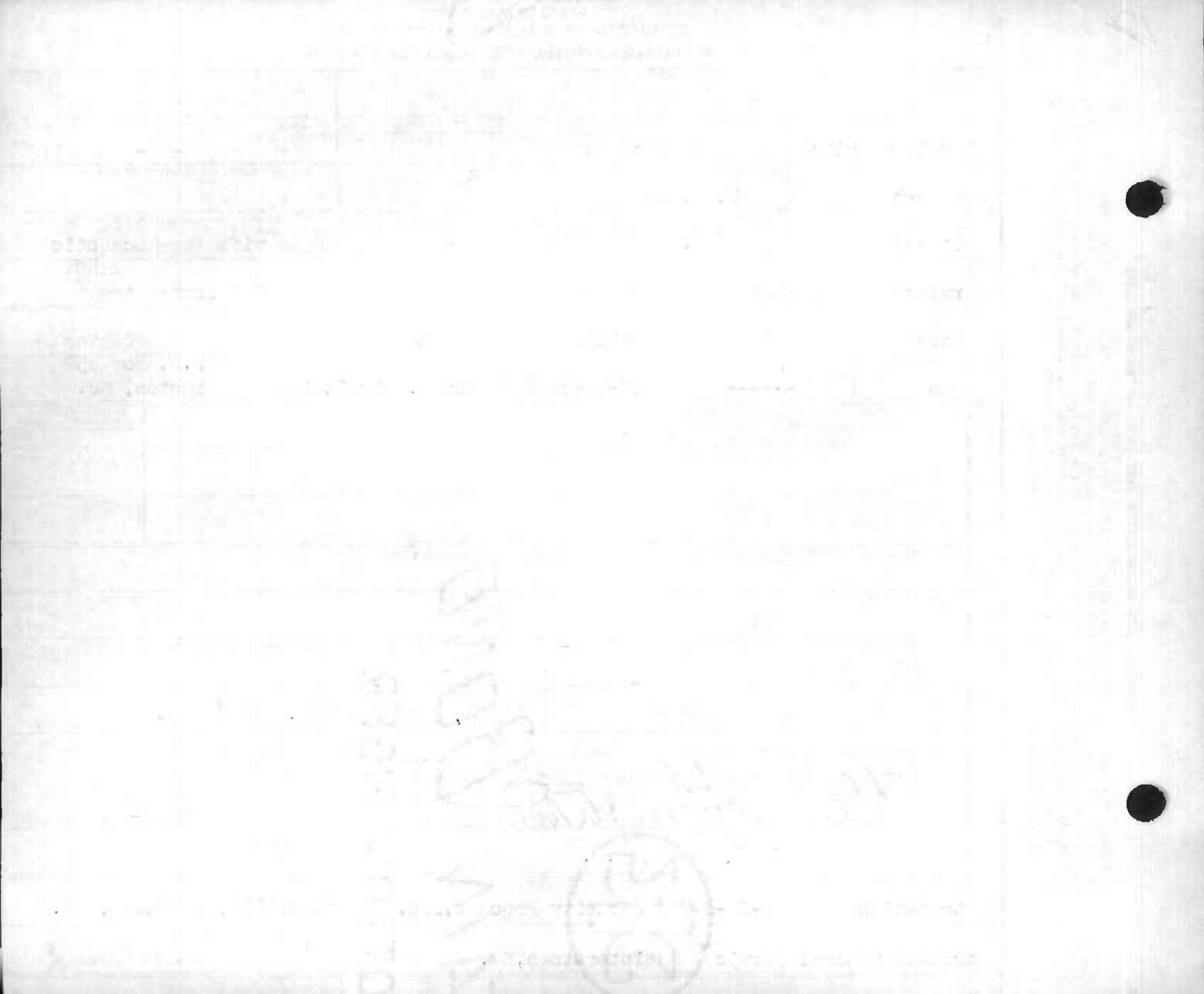
BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1-24-84 ₁₉										2b. HOUR M					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JACQUELYN CIRRINCIONE										2c. DATE PRONOUNCED DEAD 1-24-84 ₁₉										2d. HOUR M 5:05P					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 13 1952		6. AGE (IN YEARS) (LAST BIRTHDAY) 31 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 1-24-84 ₁₉										2d. HOUR M 5:05P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD													
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 200 E. Pratt Street (Harbor)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife				12b. KIND OF BUSINESS OR INDUSTRY Domestic									
13a. STATE Maryland										13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 713 Lomax Street 21601									
14. FATHER'S NAME FIRST MIDDLE LAST Jack Weishaar										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST June Carter															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				(IF YES, GIVE WAR OR DATES) -----				16b. SOCIAL SECURITY NO. 117-42-3663				17. INFORMANT ADDRESS P.O. Box 832 Easton, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 9540 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. INJURY OCCURRED										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) harbor				21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) 200 E. Pratt Street, Baltimore, Maryland																	
22a. I certify that took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																									
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 1-25-84											
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 1-25-84		23c. NAME OF CEMETERY OR CREMATORY Security Process, Inc.						23d. LOCATION (CITY OR TOWN COUNTY STATE) Catonsville, Baltimore, Md.													
24. FUNERAL DIRECTOR NAME Marzullo Funeral Service										ADDRESS Reisterstown, Md.				25a. DATE REC'D BY REGISTRAR JAN 26 1984				25b. REGISTRAR'S SIGNATURE John J. Carver							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

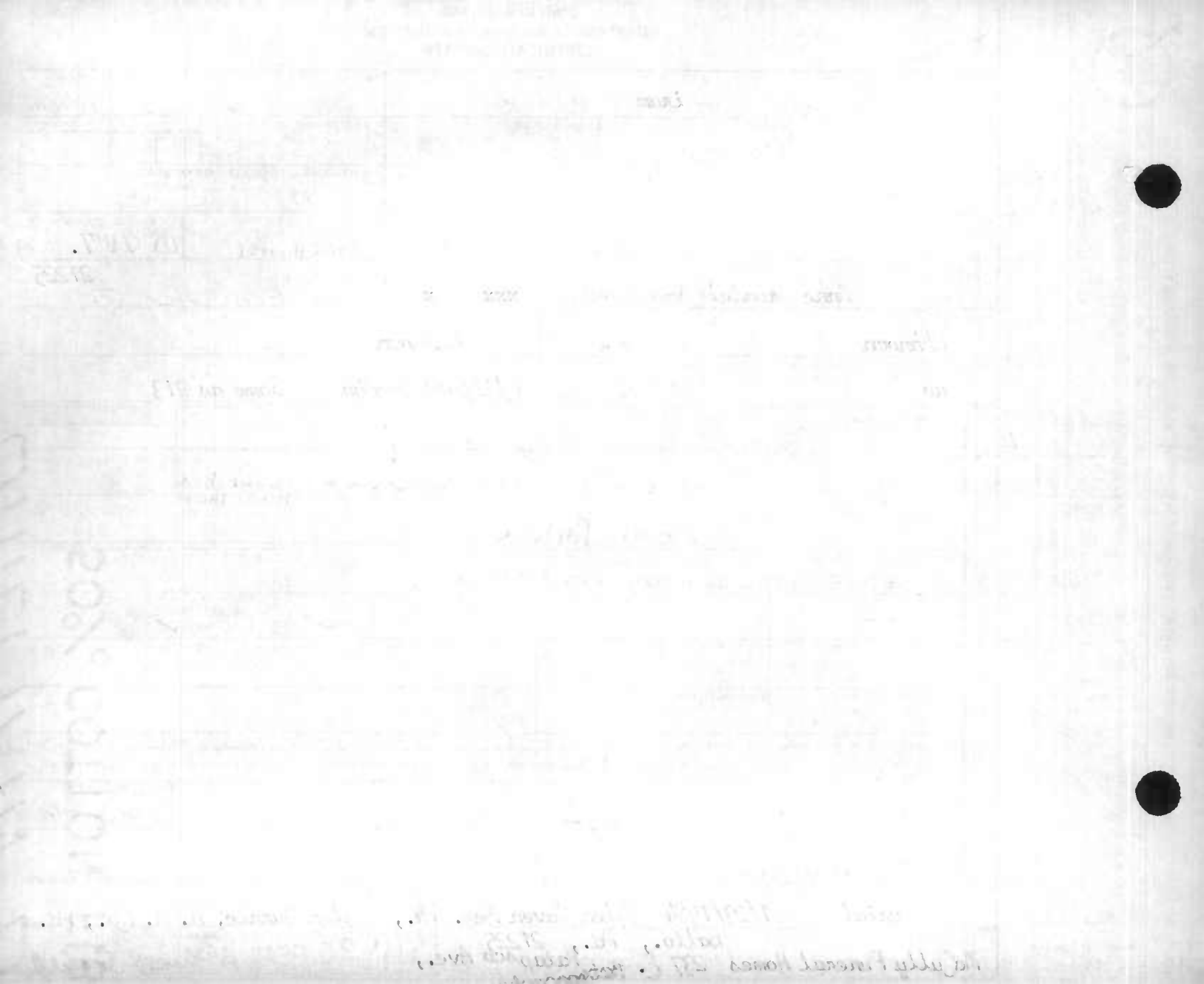
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST Charles Hiram Clark				2b. HOUR 7:25AM			
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 6-5-88		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST		12b. KIND OF BUSINESS OR INDUSTRY US GOV'T.	
13a. STATE MD		13b. COUNTY Anne Arundel		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		13e. STREET ADDRESS 431 Gillespie ST.		21225	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-32-2403		17. INFORMANT Clifford Jordan		ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 5860 DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE ASPIRATION PNEUMONIA / congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>RENAL Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>SEVERE FECAL IMPACTION, cholelithiasis,</u>							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) —			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK —		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —		21g. LOCATION CITY OR TOWN COUNTY STATE —	
22a. I certify that (I) (this hospital) attended the deceased from <u>1-10</u> , 19 <u>84</u> , to <u>1-20</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>1-20</u> , 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Rhonda Richards M.D.				DEGREE —		22c. DATE SIGNED 1-20-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Mundra				22e. ADDRESS 3001 S. Hanover			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/23/1984		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A. A. Co., Md.	
24. FUNERAL DIRECTOR NAME McUlly Funeral Homes				25a. DATE REC'D. BY REGISTRAR JAN 25 1984		25b. REGISTRAR'S SIGNATURE John J. Carrell	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 4 9

FOR 1 - STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <u>Clemson, Genevieve, R.</u>		2a. DATE OF DEATH MONTH DAY YEAR <u>01-31-84</u>	
3 SEX <u>Female</u>		2b. HOUR <u>4:30 P.M.</u>	
4. RACE <u>WHITE</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>69</u> YRS.	
5. DATE OF BIRTH MONTH DAY YEAR <u>03 26 14</u>		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>USA/ARLAW</u>		IF UNDER 24 HRS HOURS MIN.	
7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>CITY</u> MD.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>OFFICE CLERK</u>	
10. CITY OR TOWN OF DEATH <u>BALTO.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORE</u>	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>University of Md.</u>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Md.</u> 13b. COUNTY <u>Balto. City</u> 13c. CITY OR TOWN <u>Balto.</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Edward Foss</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Catherine Cassidy</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>?</u> (IF YES, GIVE WAR OR DATES) <u>?</u>		17. INFORMANT ADDRESS <u>Chant.</u>	
16b. SOCIAL SECURITY NO. <u>215-07-2558</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Biventricular Heart Failure</u> 4241 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Aortic & Mitral Valve Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aortic & Mitral Valve Replacements</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12</u> Years. <u>3-</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)			
19a. DATE OF OPERATION <u>01-31-84</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Aortic & Mitral Stenosis</u>	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>?</u>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u> P.M.	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>01-29</u> , 19 <u>84</u> , to <u>01-31</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased die on <u>01-29</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.			
22b. SIGNATURE <u>Stephen Lincoln M.D.</u> DEGREE		22c. DATE SIGNED <u>01-31-84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <u>27 So. Greene St., Balto. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>FEB 4, 1984</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MARLANO MEM. PARK</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>PARKVILLE BALTO. MARYLAND</u>	
24. FUNERAL DIRECTOR NAME <u>EVANGELINE OF MEMORIES</u>		25a. DATE REC'D. BY REGISTRAR <u>FEB 6 1984</u>	
ADDRESS <u>8800 HARFORD RD.</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Canich</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, when any injury, or other traumatic event, the medical death certificate should be filed with the medical examiner.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) JAMES O'CONNOR COADY					01 - 17 - 84							1210 PM	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 7, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Port Engineer		12b. KIND OF BUSINESS OR INDUSTRY Beth. Shipping					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Md		13b. COUNTY --		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 301 Tuscany Road 21210					
14. FATHER'S NAME FIRST MIDDLE LAST Charles Pearce Coady					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Milly Stuart Kenly								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213 16 0715		17. INFORMANT Gloria Coady		ADDRESS same							
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST SECONDARY TO PULMONARY EDEMA 1579 DUE TO, OR AS A CONSEQUENCE OF (b) PRESUMED PANCREATIC CARCINOMA WITH METASTASIS TO LIVER DUE TO, OR AS A CONSEQUENCE OF (c) ROSEBURY SEPSIS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: POSSIBLE SEPSIS, GASTROINTESTINAL BLEEDING													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 13, 19 84 to JANUARY 17, 19 84 , that (I) (we) lost saw the deceased alive on 1/17, 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE M. Keith Rawlings MD				DEGREE MD				22c. DATE SIGNED 1/17/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. KEITH RAWLINGS MD				22e. ADDRESS 801 E. UNIVERSITY PARKWAY BALTO. 21218									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/20/84		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto. Co. MD							
24. FUNERAL DIRECTOR NAME Burgee Funeral Home, 3631 Falls Road 21211				25a. DATE REC'D. BY REGISTRAR JAN 20 1984		25b. REGISTRAR'S SIGNATURE [Signature]							

BP

10/10/10
10/10/10
10/10/10
10/10/10

(1)

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 5 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bobby JOE Cobb			2a. DATE OF DEATH MONTH 1 DAY 10 YEAR 84 2b. HOUR 7:20 AM		
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH 6 DAY 16 YEAR 29	6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS		7. UNDER 1 YEARS MONTHS 0 DAYS 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oklahoma	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Balt City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Gen Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Guard - United Security		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS / ZIP CODE 802 Jack St	
14. FATHER'S NAME FIRST John MIDDLE Cobb LAST		15. MOTHER'S NAME FIRST Mamie MIDDLE Pearl LAST Doss			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 444 28 7368		17. INFORMANT ADDRESS Balto. Md. 21225	
18. CAUSE OF DEATH (Enter only one cause per line) PART 1. DEATH WAS CAUSED BY: Myocardial Infarction IMMEDIATE CAUSE (a) ASCD DUE TO, OR AS A CONSEQUENCE OF (b) ASCD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 4100					
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) _____ the body after death.					
22b. SIGNATURE George J. Gonce MD DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. KIME MD		22e. ADDRESS 3001 S HANOVER ST. BALT.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/13/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery CITY OR TOWN Brooklyn COUNTY A.A. STATE Md.	
24. FUNERAL DIRECTOR NAME George J. Gonce ADDRESS 4001 Ritchie Hwy		25a. DATE REC'D. BY REGISTRAR JAN 17 1984		25b. REGISTRAR'S SIGNATURE Joan J. Gonce	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and signed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be filed at once.

Handwritten notes at the top of the page, including "Copy for" and "Male White".

Male White
Copy for

Handwritten notes in the middle section, including "Copy for" and "Male White".

Handwritten notes in the middle section, including "Copy for" and "Male White".

Handwritten text "A-200" in the center of the page.

Handwritten letter "X" on the left side of the page.

Handwritten notes at the bottom of the page, including "Copy for" and "Male White".

Handwritten notes at the bottom of the page, including "Copy for" and "Male White".

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8400852

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BESSIE XX. COHEN			2a. DATE OF DEATH MONTH DAY YEAR 1 23 1984			2b. HOUR 8:40 PM						
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 19 1891		6. AGE (IN YEARS (LAST BIRTHDAY)) 92 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 9 23		8. IF UNDER 24 HRS. HOURS MIN. 40 00		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.						
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW GERIATRIC				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2500 W. Belvedere Ave 21215				
14. FATHER'S NAME FIRST MIDDLE LAST UNOBTAINABLE						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNOBTAINABLE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 214-03-1807		17. INFORMANT ADDRESS EMANUEL GORFINE 900 GARRETT BLDG. 233 E. REDWOOD ST. BALTO. MD 21202						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA 7070 DUE TO, OR AS A CONSEQUENCE OF (b) INFECTED ULCER RT BUTTOCK DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 07-17 , 19 81 , to 01-23 , 19 84 , that (I) (we) lost saw the deceased alive on 01-23 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE B. ZAW-WIN, M.D.						DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 01-24-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. ZAW-WIN, M.D.						22e. ADDRESS 6801 LEVINDALE GERIATRIC CTR BALTO. MD 21215						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE JAN. 25, 1984		23c. NAME OF CEMETERY OR CREMATORY BETH ISAAC ADATH ISRAEL				23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.						25. DATE REC'D. BY REGISTRAR JAN 26 1984		25. REGISTRAR'S SIGNATURE John J. Connel				
6010 REISTERSTOWN RD. BALTO., MD 21215												

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 5 3

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH				2b. HOUR	
SARAH		COHEN						SUNDAY, JAN. 15, 1984				5:15 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS.			
FEMALE		WHITE		MAY 2, 1885		98		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
LITHUANIA		USA				BALTIMORE CITY							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
BALTIMORE		7111 PARK HTS. AVE., APT. 202		HOUSEWIFE		AT HOME							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
MARYLAND		BALTIMORE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		APT. 202 7111 PARK HTS. AVE. 21215					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
LEON		SOBLE		JEANNETTE		UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		220-44-4160		MRS. BERTHA C. FLOM		APT. 202 7111 PARK HTS. AVE. BALTO., MD 21215							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Bilateral Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		1 week			
4280		DUE TO, OR AS A CONSEQUENCE OF		(b)		Congestive Heart Failure acute & chronic with							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF		(c)		Pacemaker		Years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		Pancreatitis, recurrent											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)									
		P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (the hospital) attended the deceased from		22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
saw the deceased alive on		Samuel Morrison MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		1/15/84							
above, (I) (we) (did) (did not) view the body after death		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
		SAMUEL MORRISON		11 E Chase St 21202									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
BURIAL		JAN. 16., 1984		BETH TFILOH		BALTIMORE				MARYLAND			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
SOL LEVINSON & BROS., INC.		JAN 23 1984		John J. Carver									
6010 REISTERSTOWN RD. BALTO., MD 21215													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1911

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE Jane LAST COLLE				2a. DATE OF DEATH MONTH DAY YEAR HOUR 1 4 84 1145 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 2 90		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Housework	
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST James David Patrick				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Duffy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-22-6666		17. INFORMANT ADDRESS Mary Chirico 1730 Manor Road 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1952 IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Extraabdominal Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>None</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>None</u>							
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N/A			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/> N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A			
22a. I certify that (I) (this hospital) attended the deceased from 1/4, 1984, to 1/4, 1984, that (I) (we) lost the deceased alive on 1/4, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE S. Katz				DEGREE MD		22c. DATE SIGNED 1/4/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. KATZ				22e. ADDRESS 4940 Eastern Ave BALTO MD 21224			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-7-84		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Md.	
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc.				25a. DATE REC'D. BY REGISTRAR 25b. SIGNATURE JAN 6 1984			

Handwritten notes on lined paper, including dates like 1951, 1952, and 1953, and various illegible text fragments.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ANNA M. COLEMAN				2a. DATE OF DEATH MONTH DAY YEAR 1/9/84			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 10 30 11		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Federal Hill Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired LPN		12b. KIND OF BUSINESS OR INDUSTRY Doctors Office	
13a. STATE MD		13b. COUNTY HH		13c. CITY OR TOWN Brooklyn		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Wilmer Moore				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217 26 4400		17. INFORMANT ADDRESS Bessie Mitchell same as 13 e			
18. CAUSE OF DEATH (Enter only one cause per item 18. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Acute Myocardial Infarction				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD				DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Brain Tumor & R Hemiplegia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-23- 19 76 , to 1-8- 19 84 that (I) (we) last saw the deceased alive on 1-8- 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE S. M. M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-9-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SITAIKAT Y. KHAN, M.D.		22e. ADDRESS 1528 KING WILLIAM DRIVE, BALTO, MD 21225					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/12/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md.	
24. FUNERAL DIRECTOR NAME George J. Gonce ADDRESS 4001 Ritchie Hwy.				25a. DATE REC'D. BY REGISTRAR JAN 12 1984		25b. REGISTRAR'S SIGNATURE John J. Connel	

WATKINS

NO

1944

1944

1944

1944

X

1944

1944

1944

1944

1944

1944

1944

1944

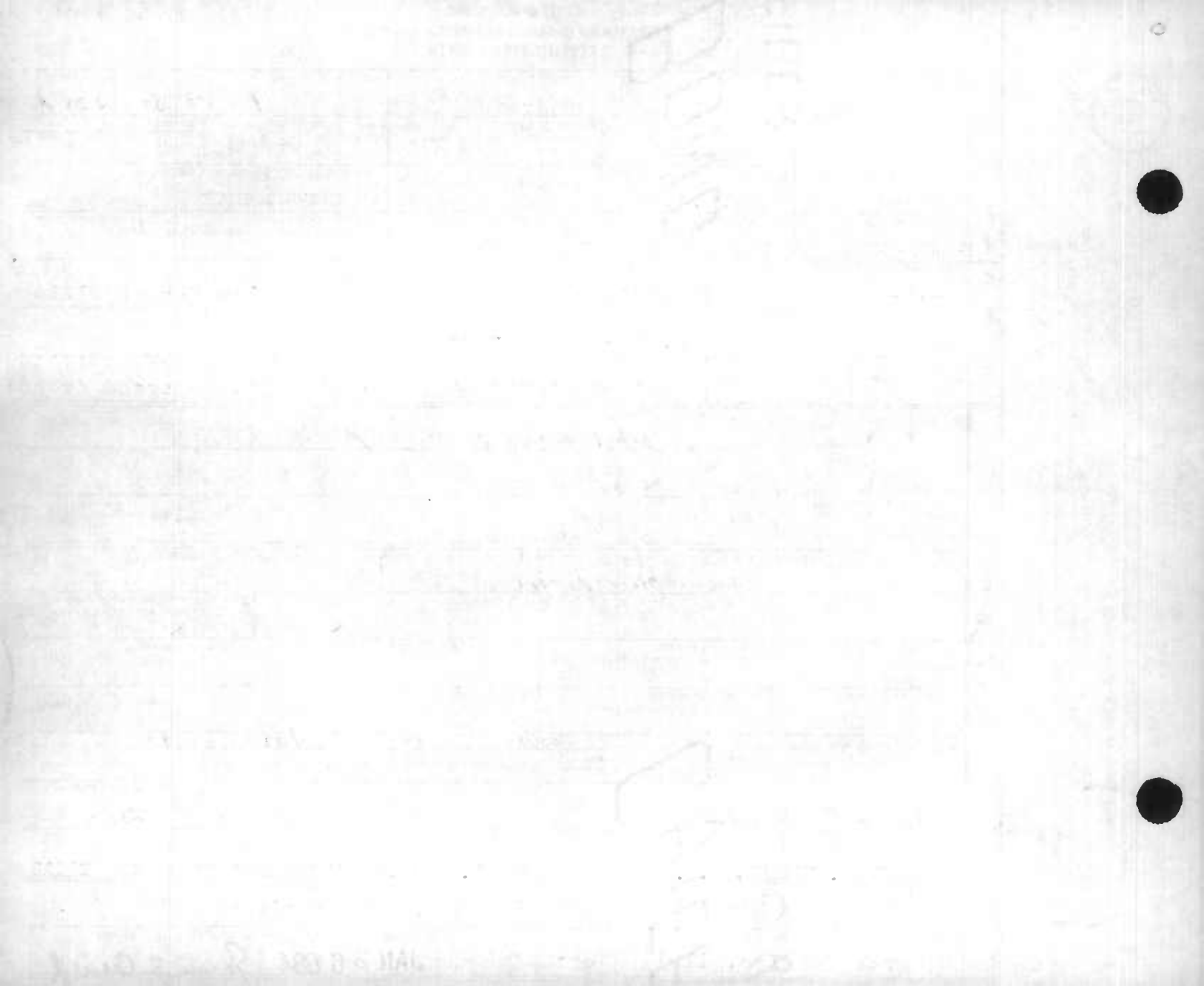
1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
JAMES L. COLLINS					1 23 89					2:25 AM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		Black		2 8 06		77 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
BALTIMORE		THE UNION MEMORIAL HOSPITAL									
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Maryland			Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		428 Worsley Street 21218		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
John Collins					Hattie						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
NO			188-10-2537		Elizabeth Collins 563 Nostrand Avenue Brooklyn, NY 11316						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> <u>6829</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>ocult abscess</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <u>anoxic brain damage</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>1/22/89</u> , 19 <u>89</u> , to <u>1/23</u> , 19 <u>89</u> , that (I) (we) lost saw the deceased alive on <u>1/22</u> , 19 <u>89</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>David M. Yousem</u>					DEGREE			22c. DATE SIGNED			
								1/23/89			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
DAVID M. YOUSEM, M.D.					201 E. UNIVERSITY PARKWAY BALTO MD 21218						
23a. BURIAL, CREMATION, REMOVAL			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
BURIAL			1/28/84		Mount Zion Cem.			Lansdowne COUNTY MD.			
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Wm C March F/H Inc. 1101 E North Avenue					JAN 26 1984			<u>John J. Connel</u>			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THOMAS — COLLISON Sr.			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 14, 1984			2b. HOUR 6:25A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 15 93		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. STATE Maryland		13b. COUNTY -----		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3317 Hudson Street 21224	
14. FATHER'S NAME FIRST MIDDLE LAST Peter ----- Collison				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary ----- Scherde					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES) -----		16b. SOCIAL SECURITY NO. 717-07-6170		17. INFORMANT ADDRESS Susan Collison 1225 Neighbors Ave. 21237			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST

4140
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

DUE TO, OR AS A CONSEQUENCE OF CORONARY ARTERY DISEASE, CONGESTIVE
(c) HEART FAILUREAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION JANUARY 13, 1984		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERMANENT FEEDING TUBE		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 5, 1983, to JANUARY 14, 1984, that (I) (we) lost saw the deceased alive on JANUARY 14, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Steve Nelson, M.D., C.M. DEGREE						22c. DATE SIGNED JAN 14, 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVE NELSON, MD.				22e. ADDRESS CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MD 21231			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-18-84		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Md.	
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son, Inc.				ADDRESS 901 S. Conkling		25a. DATE REC'D. BY REGISTRAR JAN 17 1984	
						25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Block

Unit

3

17

22

99

Section

10

10

Section 10

Section

10

10

Section 10

Section

10

10

Section

10

10

10

10

10



10

10

10

10

10

10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Catherine Augusta Connor		2a. DATE OF DEATH MONTH DAY YEAR Jan 13 84		2b. HOUR 9:10 AM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 70 77 19		6. AGE (IN YEARS LAST BIRTHDAY) 64	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN NURSING FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housework		12b. KIND OF BUSINESS OR INDUSTRY At Home
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie E. Britt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-01-2598		17. INFORMANT ADDRESS Edward G. Connor Sr. 1315 Bonsal St. 21224	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) hypertension					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) diabetes, CORN					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 19 84, to Jan 13, 19 84, that (I) (we) last saw the deceased alive on Jan 17, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Steven J. Keith		DEGREE		22c. DATE SIGNED 1-17-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven J. Keith		22e. ADDRESS 4940 Eastern Ave			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-16-84		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cem.	
23d. LOCATION (CITY OR TOWN COUNTY STATE) Dundalk, Balto. Co., Md.		23e. DATE REC'D. BY REGISTRAR JAN 17 1984			
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc.		ADDRESS 6224 Eastern Ave.		25b. REGISTRAR'S SIGNATURE John J. Connor	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in its entirety, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 7 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) KEITH Eric Connor										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 1-24-84	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH June 28 '59	6. AGE (IN YEARS) 24 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD 1-24-84	2d. HOUR 11:50				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2000 Eutaw Place				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Therapeutic Asst.		12b. KIND OF BUSINESS OR INDUSTRY Sheppard-Pratt Hospital			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1701 N. Monroe Street			
14. FATHER'S NAME FIRST MIDDLE LAST Arlington Phillips				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christine Connor							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 215 78 3997		17. INFORMANT ADDRESS Christine C. Stuart 1711 N. Monroe St. 21216					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9654 IMMEDIATE CAUSE (a) Gunshot wound's to abdomen and chest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:44 PM 1-24-84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION 2000 Eutaw Place Baltimore, Maryland					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER Dennis F. Smyth, M.D.			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/28/84		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Pk.				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Nutter & Sons 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216						DATE REC'D. BY REGISTRAR JAN 27 1984		25. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP

3301A 1010

3301A 1010



General Jones and
2501 Gwynn Falls Hwy.
Baltimore, Maryland 21216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR						8 4 0 0 3 6 0					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THOMAS F. COOGAN SR.						2a. DATE OF DEATH MONTH DAY YEAR 1/17/1984				2b. HOUR 2:08 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1/28/1917		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 66 YRS.		IF UNDER 1 YEAR HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION Ret./J.E. Appt. Physic			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Md. Baltimore, Catonsville						13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS ZIP CODE 205 Ingleside Avenue 21228			
14. FATHER'S NAME FIRST MIDDLE LAST Patrick Coogan						15. MOTHER'S MAIDEN NAME FIRST MIDDLE Catherine O'hlea					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW 2				16b. SOCIAL SECURITY NO. 215-10-5569		17. INFORMANT ADDRESS Thomas F. Coogan Jr. - Baltimore, Md. 21229					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4310 IMMEDIATE CAUSE (a) Respiratory arrest. DUE TO, OR AS A CONSEQUENCE OF (b) massive cerebral edema & herniation house DUE TO, OR AS A CONSEQUENCE OF (c) massive intracerebral & intraventricular hemorrhage										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (his hospital) attended the deceased from 1/17/1984 to 1/18/1984, that (I) (we) last saw the deceased alive on 1/18/1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Chalabi						DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/17/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. EDWARD LAYNE						22e. ADDRESS 900 S. Caton Ave., Baltimore, Md. 21229					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment				23b. DATE 1/21/84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Mausoleum		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228						25a. DATE REC'D. BY REGISTRAR JAN 19 1984		25b. REGISTRAR'S SIGNATURE [Signature]			

10:10

Paterson
Cogan
Lester
Thompson, F. Cogan, Jr., - Baltimore, Md. 21222
Yes 2 212-10-555

1030 Remington Arms, Baltimore, Md. 21222
Lester
Cogan
Thompson, F. Cogan, Jr., - Baltimore, Md. 21222
Yes 2 212-10-555

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Louis C. Cook			2a. DATE OF DEATH MONTH DAY YEAR 1 9 84 2b. HOUR 10 ⁰⁷ AM		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 08 14 10	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEATON MED CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY M.T.A.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. CITY OR TOWN Catonsville		
14. FATHER'S NAME FIRST MIDDLE LAST Charles C. Cook			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Hanfmann		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213-10-0024	17. INFORMANT ADDRESS Elizabeth B. Steinwedel 1010 Southridge Rd. Catonsville, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>CORONARY ARTERY DISEASE, Cerebrovascular accident, Depression</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>Nov. 11</u> , 19 <u>83</u> , to <u>JAN. 9</u> , 19 <u>84</u> , that (1) (we) last saw the deceased alive on <u>JAN. 9</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, so state.) (Do not view the body after death.)					
22b. SIGNATURE <u>Charles Rosenkars, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/9/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>(CHARLES) ROSENKARS, M.D.</u>		22e. ADDRESS Deaton Medical Center, Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (CHECK) Entombment		23b. DATE 01-12-84	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery Woodlawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD.
24. FUNERAL DIRECTOR NAME Leroy M. & Russell C. Witzke		ADDRESS 1630 Edmondson Ave. Catonsville, MD.		25. DATE REC'D. BY REGISTRAR JAN 10 1984	
26. REGISTRAR'S SIGNATURE <u>John J. Connel</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Jarvis M. A. Russell, C. W. Winkler, Catonsville, MD.

1930 Lombard Ave.

01-12-61

Forrestine Park Cemetery, Woodlawn

Baltimore, MD.



Handwritten notes and signatures, including a large '8' and '10'.

CHURCH OF THE ANGELS

213-10-0024 Elizabeth H. Steinbock

Catonsville, MD.

1000 South Ridge Rd.

Joachim

Good

C.

Charles

2130 Old Frederick Rd.

2130

Heckman

Baltimore

W.L.A.

Harvey

Baltimore City

W.L.A.

W.L.A.

01 11 01

73

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 4 0 0 3 6 2					
1. FOR STATE REGISTRAR			REG. NO.								
1 DECEASED NAME (TYPE OR PRINT) George K. Cooper			2a DATE OF DEATH MONTH DAY YEAR 1 28 84			2b HOUR 10 ¹² P.M.					
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 9 17 1919		6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7a IF UNDER 1 YEAR MONTHS DAYS		7b IF UNDER 24 HRS HOURS MIN.	
7c BIRTHPLACE (STATE OR FOREIGN COUNTRY) FLORIDA		7d CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MT. SINAI Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. CITY OR TOWN BALT.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 1815 POPLAR GROVE ST.				
14 FATHER'S NAME FIRST MIDDLE LAST John Cooper			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flossie Wilson			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.					
16b SOCIAL SECURITY NO. 212-28-4283			17 INFORMANT Ruth Cooper			ADDRESS 1815 Poplar Grove St. Baltimore, Maryland 21216					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA 5070 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): CIA											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) (this hospital) attended the deceased from March 14, 1978, to Jan 28, 1984, that I (we) lost saw the deceased alive on 1-28-84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b SIGNATURE RUTH M. WEBER MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 1-28-84		
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS 3640 FOX WOOD 21215								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 2/3/84		23c NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24 FUNERAL DIRECTOR NAME NUTTER & SONS			25a ADDRESS 2501 GWYNNS FALLS PARK			25b DATE REC'D. BY REGISTRAR FEB 3 1984			25c REGISTRAR'S SIGNATURE John J. [Signature]		
FUNERAL HOME INC. BALTO. MD. 21216											

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1003. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
1- FOR STATE REGISTRAR Item 13a thru e phone 1-23-84 cn										MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)						FIRST		MIDDLE		LAST	
2a. DATE KNOWN OF DEATH						<input checked="" type="checkbox"/> MONTH		DAY		YEAR	
2b. HOUR						2c. DATE PRONOUNCED DEAD		MONTH		DAY	
3. SEX						4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)						7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE						13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
17. INFORMANT						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20. AUTOPSY?	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY	
21i. STATE						21j. DATE REC'D BY REGISTRAR		21k. REGISTRAR'S SIGNATURE		21l. DATE	
21m. CITY OR TOWN						21n. COUNTY		21o. STATE		21p. DATE	
21q. NAME OF CEMETERY OR CREMATORY						21r. LOCATION		21s. CITY OR TOWN		21t. COUNTY	
21u. STATE						21v. DATE		21w. CITY OR TOWN		21x. COUNTY	
21y. NAME OF CEMETERY OR CREMATORY						21z. LOCATION		21aa. CITY OR TOWN		21ab. COUNTY	
21ac. STATE						21ad. DATE		21ae. CITY OR TOWN		21af. COUNTY	
21ag. NAME OF CEMETERY OR CREMATORY						21ah. LOCATION		21ai. CITY OR TOWN		21aj. COUNTY	
21ak. STATE						21al. DATE		21am. CITY OR TOWN		21an. COUNTY	
21ao. NAME OF CEMETERY OR CREMATORY						21ap. LOCATION		21aq. CITY OR TOWN		21ar. COUNTY	
21as. STATE						21at. DATE		21au. CITY OR TOWN		21av. COUNTY	
21aw. NAME OF CEMETERY OR CREMATORY						21ax. LOCATION		21ay. CITY OR TOWN		21az. COUNTY	
21ba. STATE						21bb. DATE		21bc. CITY OR TOWN		21bd. COUNTY	
21be. NAME OF CEMETERY OR CREMATORY						21bf. LOCATION		21bg. CITY OR TOWN		21bh. COUNTY	
21bi. STATE						21bj. DATE		21bk. CITY OR TOWN		21bl. COUNTY	
21bm. NAME OF CEMETERY OR CREMATORY						21bn. LOCATION		21bo. CITY OR TOWN		21bp. COUNTY	
21bq. STATE						21br. DATE		21bs. CITY OR TOWN		21bt. COUNTY	
21bu. NAME OF CEMETERY OR CREMATORY						21bv. LOCATION		21bw. CITY OR TOWN		21bx. COUNTY	
21by. STATE						21bz. DATE		21ca. CITY OR TOWN		21cb. COUNTY	
21cd. NAME OF CEMETERY OR CREMATORY						21ce. LOCATION		21cf. CITY OR TOWN		21cg. COUNTY	
21ch. STATE						21ci. DATE		21cj. CITY OR TOWN		21ck. COUNTY	
21cl. NAME OF CEMETERY OR CREMATORY						21cm. LOCATION		21cn. CITY OR TOWN		21co. COUNTY	
21cp. STATE						21cq. DATE		21cr. CITY OR TOWN		21cs. COUNTY	
21ct. NAME OF CEMETERY OR CREMATORY						21cu. LOCATION		21cv. CITY OR TOWN		21cw. COUNTY	
21cx. STATE						21cy. DATE		21cz. CITY OR TOWN		21da. COUNTY	
21db. NAME OF CEMETERY OR CREMATORY						21dc. LOCATION		21dd. CITY OR TOWN		21de. COUNTY	
21df. STATE						21dg. DATE		21dh. CITY OR TOWN		21di. COUNTY	
21dj. NAME OF CEMETERY OR CREMATORY						21dk. LOCATION		21dl. CITY OR TOWN		21dm. COUNTY	
21dn. STATE						21do. DATE		21dp. CITY OR TOWN		21dq. COUNTY	
21dr. NAME OF CEMETERY OR CREMATORY						21ds. LOCATION		21dt. CITY OR TOWN		21du. COUNTY	
21dv. STATE						21dw. DATE		21dx. CITY OR TOWN		21dy. COUNTY	
21dz. NAME OF CEMETERY OR CREMATORY						21ea. LOCATION		21eb. CITY OR TOWN		21ec. COUNTY	
21ed. STATE						21ee. DATE		21ef. CITY OR TOWN		21eg. COUNTY	
21eh. NAME OF CEMETERY OR CREMATORY						21ei. LOCATION		21ej. CITY OR TOWN		21ek. COUNTY	
21el. STATE						21em. DATE		21en. CITY OR TOWN		21eo. COUNTY	
21er. NAME OF CEMETERY OR CREMATORY						21es. LOCATION		21et. CITY OR TOWN		21eu. COUNTY	
21ev. STATE						21ew. DATE		21ex. CITY OR TOWN		21ey. COUNTY	
21ez. NAME OF CEMETERY OR CREMATORY						21fa. LOCATION		21fb. CITY OR TOWN		21fc. COUNTY	
21fd. STATE						21fe. DATE		21ff. CITY OR TOWN		21fg. COUNTY	
21fh. NAME OF CEMETERY OR CREMATORY						21fi. LOCATION		21fj. CITY OR TOWN		21fk. COUNTY	
21fl. STATE						21fo. DATE		21fp. CITY OR TOWN		21fq. COUNTY	
21fr. NAME OF CEMETERY OR CREMATORY						21fs. LOCATION		21ft. CITY OR TOWN		21fu. COUNTY	
21fv. STATE						21fw. DATE		21fx. CITY OR TOWN		21fy. COUNTY	
21fz. NAME OF CEMETERY OR CREMATORY						21ga. LOCATION		21gb. CITY OR TOWN		21gc. COUNTY	
21gd. STATE						21ge. DATE		21gf. CITY OR TOWN		21gg. COUNTY	
21gh. NAME OF CEMETERY OR CREMATORY						21gi. LOCATION		21gj. CITY OR TOWN		21gk. COUNTY	
21gl. STATE						21go. DATE		21gp. CITY OR TOWN		21gq. COUNTY	
21gr. NAME OF CEMETERY OR CREMATORY						21gs. LOCATION		21gt. CITY OR TOWN		21gu. COUNTY	
21gv. STATE						21gw. DATE		21gx. CITY OR TOWN		21gy. COUNTY	
21gz. NAME OF CEMETERY OR CREMATORY						21ha. LOCATION		21hb. CITY OR TOWN		21hc. COUNTY	
21hd. STATE						21he. DATE		21hf. CITY OR TOWN		21hg. COUNTY	
21hi. NAME OF CEMETERY OR CREMATORY						21ho. LOCATION		21hp. CITY OR TOWN		21hq. COUNTY	
21hr. STATE						21hs. DATE		21ht. CITY OR TOWN		21hu. COUNTY	
21hv. NAME OF CEMETERY OR CREMATORY						21ht. LOCATION		21hu. CITY OR TOWN		21hv. COUNTY	
21hw. STATE						21ia. DATE		21ib. CITY OR TOWN		21ic. COUNTY	
21id. NAME OF CEMETERY OR CREMATORY						21id. LOCATION		21ie. CITY OR TOWN		21if. COUNTY	
21ie. STATE						21ie. DATE		21if. CITY OR TOWN		21ig. COUNTY	
21if. NAME OF CEMETERY OR CREMATORY						21if. LOCATION		21if. CITY OR TOWN		21ih. COUNTY	
21ig. STATE						21ig. DATE		21ig. CITY OR TOWN		21ii. COUNTY	
21ih. NAME OF CEMETERY OR CREMATORY						21ih. LOCATION		21ih. CITY OR TOWN		21ij. COUNTY	
21ij. STATE						21ij. DATE		21ij. CITY OR TOWN		21ik. COUNTY	
21ik. NAME OF CEMETERY OR CREMATORY						21ik. LOCATION		21ik. CITY OR TOWN		21il. COUNTY	
21il. STATE						21il. DATE		21il. CITY OR TOWN		21im. COUNTY	
21im. NAME OF CEMETERY OR CREMATORY						21im. LOCATION		21im. CITY OR TOWN		21in. COUNTY	
21in. STATE						21in. DATE		21in. CITY OR TOWN		21io. COUNTY	
21io. NAME OF CEMETERY OR CREMATORY						21io. LOCATION		21io. CITY OR TOWN		21ip. COUNTY	
21ip. STATE						21ip. DATE		21ip. CITY OR TOWN		21iq. COUNTY	
21iq. NAME OF CEMETERY OR CREMATORY						21iq. LOCATION		21iq. CITY OR TOWN		21ir. COUNTY	
21ir. STATE						21ir. DATE		21ir. CITY OR TOWN		21is. COUNTY	
21is. NAME OF CEMETERY OR CREMATORY						21is. LOCATION		21is. CITY OR TOWN		21it. COUNTY	
21it. STATE						21it. DATE		21it. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF CEMETERY OR CREMATORY						21iu. LOCATION		21iu. CITY OR TOWN		21iv. COUNTY	
21iv. STATE						21iv. DATE		21iv. CITY OR TOWN		21iu. COUNTY	
21iu. NAME OF C											

THE SECRETARY OF THE ARMY
WASHINGTON, D. C.
JAN 28 1945

TO THE SECRETARY OF THE ARMY
FROM THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]

93810110

1- STATE
REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2c. HOUR	
Charles A. Corbin								1-10 1984								5:05 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Black	12 27 43		40 YRS.						1-10 1984							
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		U.S.A.				Baltimore City,											
CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12c. KIND OF BUSINESS OR INDUSTRY											
Baltimore		4622 Manordene Rd., C-1															
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		424 Edgewood Street		21229					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Abdullah Shareef		Anita Carter															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
YES		216-42-4290		Anita Coates		1528 N. Ellamont Ave.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
3049 Intravenous Narcotism																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															
20. AUTOPSY?																	
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
				CITY OR TOWN		COUNTY		STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Dennis F. Smyth, M.D.		M.D. Assistant MEDICAL EXAMINER		1-11-84													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Dennis F. Smyth, M.D.		111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
BURIAL		1/13/84		King Memorial Park		Randallstown,											
						COUNTY		STATE									
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE											
Wm C March F/H Inc.		1101 E North Avenue		JAN 17 1984		John J. Grier											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MARY MIDDLE CORNISH LAST		MONTH DAY YEAR HOUR	
3. SEX F.		4. RACE NEGRO	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MONTH DAY YEAR		YEARS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
M.D.		U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
BALTO.		M and Hotel	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12b. KIND OF BUSINESS OR INDUSTRY	
1700 E. LAFAYETTE AVE		Hotel	
13a. STATE		13b. COUNTY	
MD		BALTO	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
BALTO		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS		13f. STREET ADDRESS	
1700 E. LAFAYETTE AVE		1700 E. LAFAYETTE AVE	
4. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST		FIRST MIDDLE LAST	
JOSEPH STANLEY		LOUISE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
NO		215-01-4444	
17. INFORMANT		ADDRESS	
DOLORES KELSO		1700 E. LAFAYETTE AVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> 4029 DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) <u>longstanding hypertension</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	
P.M.		HOUR A.M. MONTH DAY YEAR	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>December</u> , 19 <u>82</u> , to <u>January</u> , 19 <u>84</u> , that (1) (we) last saw the deceased alive on <u>December</u> , 19 <u>83</u> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		22c. DATE SIGNED	
DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
ESSIE J. WOODS		Johns Hopkins Hospital 600 N. Wolfe St. Baltimore, MD 21205	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		2/4/84	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
MT. CARMEL		A.H. County MD STATE	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
NAME ADDRESS		25b. REGISTRAR'S SIGNATURE	
Locks FUNERAL Home 1304 N. Central Ave		JAN 31 1984	

CONFIDENTIAL
TOP SECRET
- 24 -

[Faint, mostly illegible text and markings covering the page, possibly bleed-through from the reverse side. Some faint words like "CONFIDENTIAL" and "TOP SECRET" are visible.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2b. DATE OF DEATH			2c. HOUR		
FIRST MIDDLE LAST ROSE CORNISH			MONTH DAY YEAR 1 30 84			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Female	Black	MONTH DAY YEAR 11 3 34	49 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	U.S.A.		BALTIMORE CITY, MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	CHURCH HOME HOSPITAL							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland						Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Edgar			Mamie			Gant		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
UNKNOWN						Earl S. Cornish 816 N. Central Ave.		
18. CAUSE OF DEATH (Enter only one cause prevailing for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE <i>several yrs</i> DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE <i>slowly yrs</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH FEW HOURS								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) MALIGNANT OBESITY								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
N/A			N/A			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
N/A			N/A			N/A		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
N/A			N/A			N/A		
22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 4, 1986 , to JANUARY 6, 1984 , that (I) (we) last saw the deceased alive on JANUARY 6, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Josefina T. Naraval						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Feb. 1, 1984
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEFINA T. NARAVAL						22e. ADDRESS 1017 E. Baltimore BALTIMORE MD		
23a. BURIAL, CREMATION, REMOVAL			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL			2/24/84		Eastview Mem. Pk.		Baltimore, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc. 1101 E North Avenue						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE [Signature]
						FEB 2 1984		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

THE UNIVERSITY OF CHICAGO

CHIEF



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked children, all other children 18 years of age or younger must be marked on this certificate.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARY			2a. DATE OF DEATH MONTH DAY YEAR 1 19 84			2b. HOUR 12:15AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 27 1903		6. AGE (IN YEARS LAST BIRTHDAY) 80		7. IF UNDER 1 YEAR MONTHS DAYS 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, Baltimore, Maryland 21218				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home making	
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Joppa, Md.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1112 Old Mt. Rd. Joppa, Md. 21085	
14. FATHER'S NAME FIRST MIDDLE LAST Leander Wade				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabelle Bayers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. 11 220 10 2386		17. INFORMANT Rehoboth, Del. 32 Carriage Lane Mrs. Maxine Simpson, Colonial East, Box 541			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2051 IMMEDIATE CAUSE (a) Upper GI bleed DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic myelogenous Leukemia, Ulcers of mouth (unknown etiology)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 9 , 19 84 , to JANUARY 19 , 19 84 , that (I) (we) last saw the deceased alive on JANUARY 19 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert Loeb MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/19/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Loeb, M.D.						22e. ADDRESS VAMC, Baltimore, Maryland 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-23-1984		23c. NAME OF CEMETERY OR CREMATORY Baltimore Natl. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR NAME E.F. Lassam, 11750 Belair Rd. Kingsville, Md. 21088						25. DATE REC'D BY REGISTRAR JAN 25 1984			
26. REGISTRAR'S SIGNATURE John J. Grier									

BP

RECEIVED
JAN 10 1964
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]

1 - [Illegible]

1 - [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ROBERT COUGHENOUR				2a. DATE OF DEATH MONTH DAY YEAR 1/27/84 11:25 AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3 8 1904		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Boarding Home	
13a. STATE MD				13b. COUNTY BALTIMORE		13c. CITY OR TOWN Balto.	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 314-03-2178		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7 5070 IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF ASPIRATION PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/27 19 80 , to 1/27 19 80 , that (I) (we) last saw the deceased alive on 1/27 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Leduvina L. Cueto				DEGREE		22c. DATE SIGNED 1/27/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEDUVINA L. CUETO				22e. ADDRESS LUTHERAN HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 1/30/84		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board				25. DATE REC'D BY REGISTRAR FEB 03 1984 REGISTRAR'S SIGNATURE John J. Casper			

BP

FEB 03 1984

John G. Smith

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) BLANCHE E. COULTER			2a. DATE OF DEATH MONTH DAY YEAR January 2, 1984			2b. HOUR 11:00 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 8, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6824 Sturbridge Dr. # D		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Office	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Francis Choupin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 10 8832		17. INFORMANT ADDRESS Wilmer V. Coulter, Jr., Pasadena, MD			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

4100

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 day

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 7-26, 1974, to 11-1, 1983, that (I) (we) last saw the deceased alive on 11-21, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE A.H. Ghiladi				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-3-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. A. H. Ghiladi, M. D.				22e. ADDRESS 7600 Osler Drive, Balto., MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/5/84		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. County, MD	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD				25a. DATE REC'D. BY REGISTRAR JAN 3 1984		25b. REGISTRAR'S SIGNATURE John J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed (filled in by the funeral director), page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1031, 6. 05-1

1990

ny>ru

Page 01 318

7000 Callaghan Drive, Palo Alto, CA 94304

yes! / yes!

...to ...

[illegible]

MEDICAL CERTIFICATION

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "in" are visible.]

Handwritten signature: *John S. [illegible]*
Printed text: JAN 28 1964

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

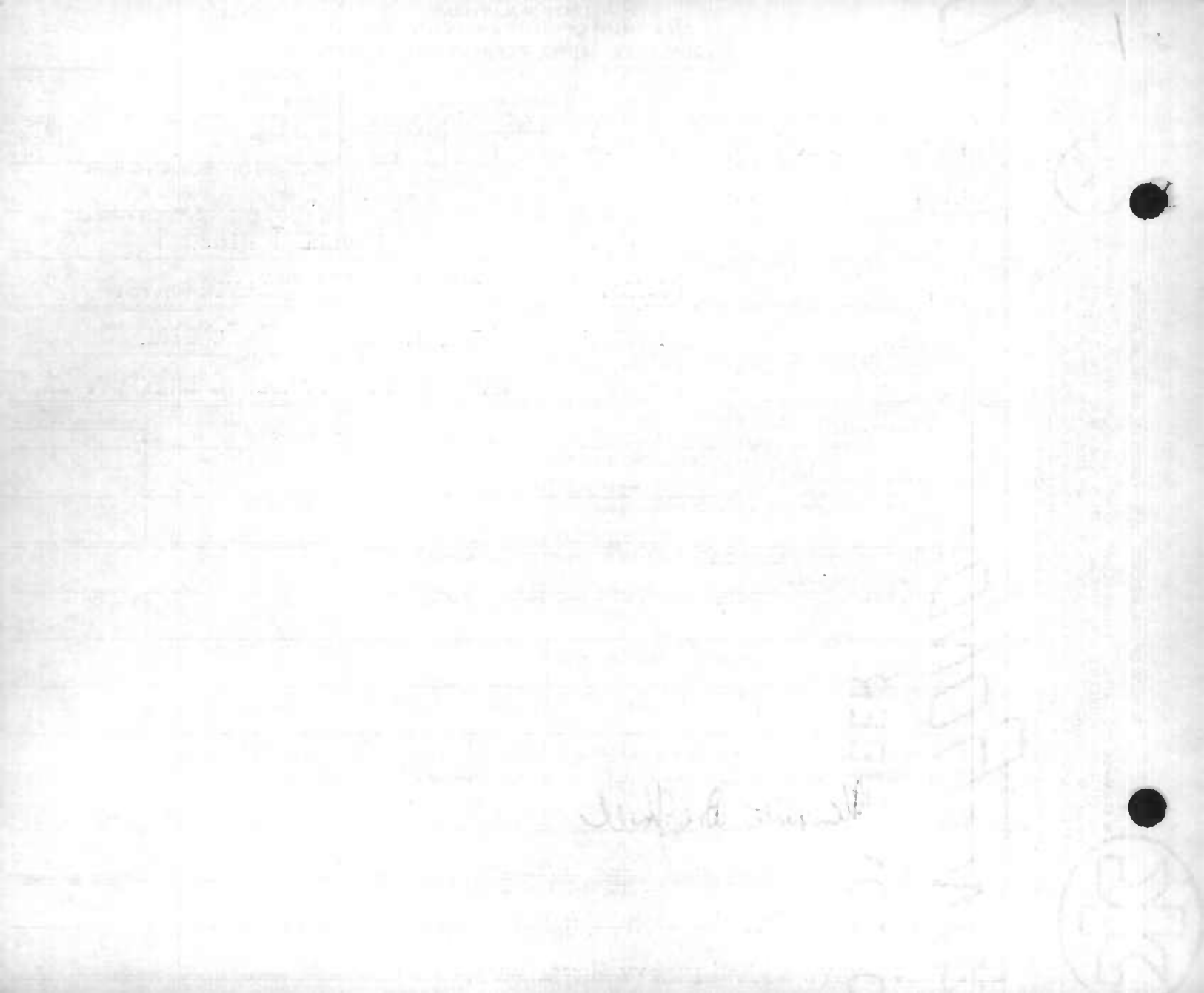
DHMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Evelyn			MIDDLE Covington			LAST			20. DATE OF DEATH OF ESTI- MATED <input checked="" type="checkbox"/> 1-26 1984			2b. HOUR 5:40 p.m.		
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 1 8 30		6. AGE (IN YEARS) (BIRTHDAY) 54 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD 1-26 1984			2d. HOUR 5:40 p.m.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO., Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING TIME) DOUBLE T DINER				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.				13b. COUNTY BALTO.				13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13d. STREET ADDRESS 4311 BELLVIEW AVE.					
14. FATHER'S NAME FIRST MIDDLE LAST PARKER COVINGTON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GEORGIANNA MCNEILL													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO.				17. INFORMANT MARY JACOB				ADDRESS 3 WALDEN CHERRY CT. 21207					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from _____ Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 1-27-84					
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/31/84				23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN				23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., Md.					
24. FUNERAL DIRECTOR NAME LEROY O. DYETT				ADDRESS 4600 LIBERTY HGTS. AVE.				25a. DATE REC'D. BY REGISTRAR JAN 30 1984				25b. REGISTRAR'S SIGNATURE <i>Be g. B...</i>					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 7 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELSIE NMI COX			2a. DATE OF DEATH MONTH DAY YEAR 01 30 84			2b. HOUR 0014 M	
3. SEX F		4. RACE N V		5. DATE OF BIRTH MONTH DAY YEAR 02 01 96		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MARYLAND HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND				13b. COUNTY BALTIMORE CITY		13c. CITY OR TOWN BALTIMORE CITY	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES EDWARDS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUSAN EDWARDS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) UNKNOWN		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS (INPATIENT REGISTRATION) ROXIE BACHMAN 310 WILSON COURT BALTIMORE, MD.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3485 IMMEDIATE CAUSE (a) VENTRICULAR ARRHYTHMIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 HOURS
DUE TO, OR AS A CONSEQUENCE OF (b) TENTORIAL HERNIATION		4 DAYS
DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL EDEMA		4 DAYS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

NONE

19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/29 , 19 84 , to 1/30 , 19 84 , that (I) (we) lost saw the deceased alive on 1/30 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bruce I Lobar MD				DEGREE		22c. DATE SIGNED 01 30 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE I LOBAR MD				22e. ADDRESS DEPT. OF NEUROLOGY, UNIV. OF MD. HOSPITAL BALTIMORE, MD.			

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE 2/5/84		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION CITY OR TOWN COUNTY STATE NORTH HUMBOLDT VA	
24. FUNERAL DIRECTOR NAME ADDRESS V.R. Bailey 1348 N. Calhoun ST				25a. DATE RECEIVED BY REGISTRAR JAN 31 1984			
25b. REGISTRAR'S SIGNATURE [Signature]							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6521E NMI 02X 01 30 84 0014

F 1 01 84 87

UZA * UZA BATHUR CITY

CITY UNIV. OF WASHINGTON K270 HOSKINS

WASH DC 20007 1218 WASHINGTON STATE

CHARGE 20007

UNIFORM NONE (INVESTIGATION) DATE EACH YEAR

1/2 MONTH

TEMPORARY RECORD

GENERAL EVENT

NONE

NONE

1/30 1/30 1/30 1/30

1/30 1/30 1/30 1/30

1/30 1/30 1/30 1/30

1/30 1/30 1/30 1/30

1/30 1/30 1/30 1/30

1/30 1/30 1/30 1/30

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. PAGE 6 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 7 FOR YOUR FILES. PAGE 8 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 9 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

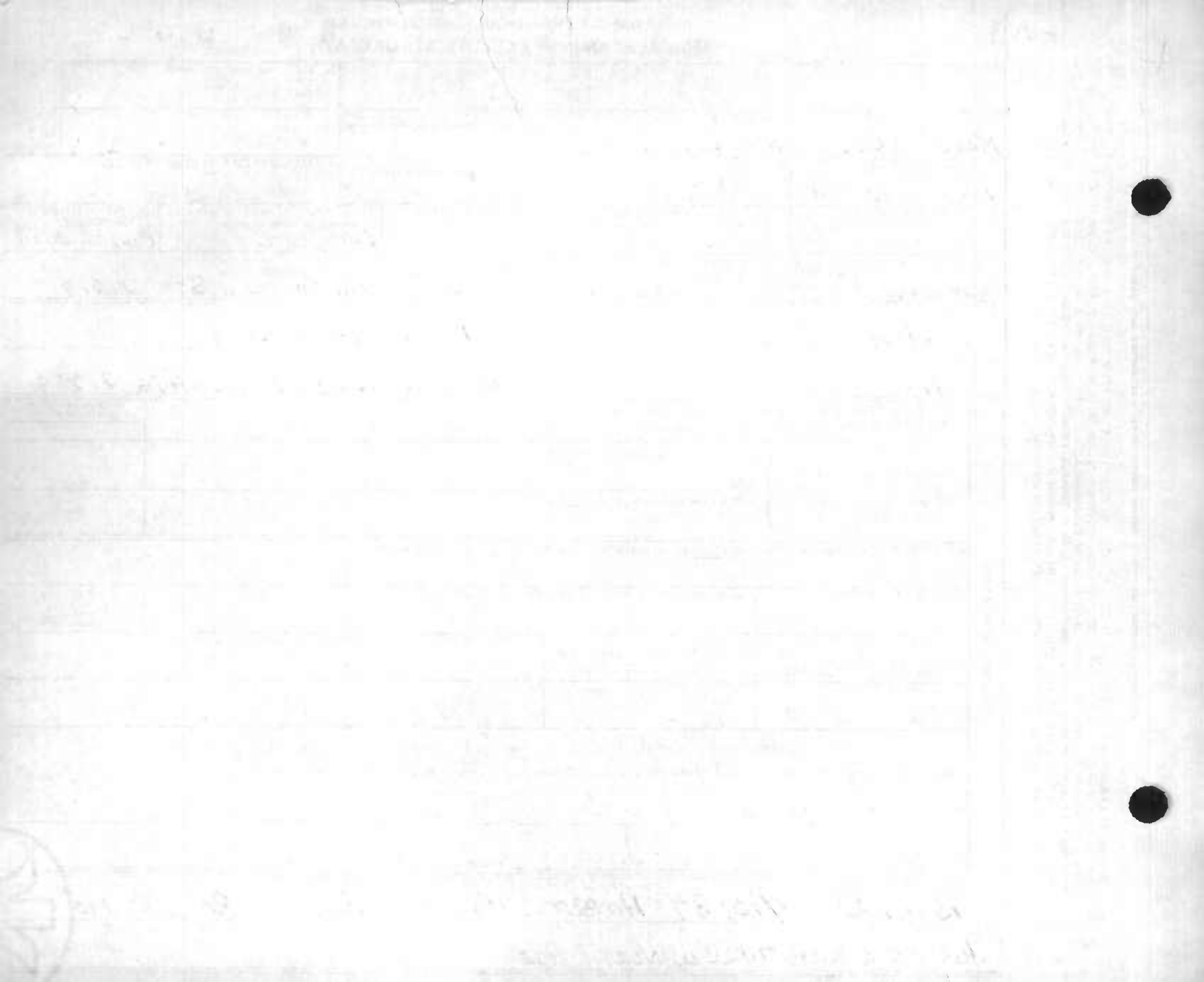
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST Sheldon MIDDLE COX LAST			2a. DATE KNOWN OF DEATH MONTH DAY YEAR XX 1-3 19 84 DEATH MATED <input type="checkbox"/> 1-3 19 84			2b. HOUR M 8:46 P. M	
3. SEX MALE	4. RACE COL 2	5. DATE OF BIRTH MONTH DAY YEAR MAY 16 1961 22 YRS.	6. AGE (IN YEARS) LAST BIRTHDAY 22 YRS.	IF UNDER 1 YR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-3 1984	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 644 W. Mosher Street - alley				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER	
12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION							
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 731 DOLPHIN ST		21217					
14. FATHER'S NAME FIRST MIDDLE LAST JERU COX			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOLA HUTCHINS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS LOLA COX 2217 LINCOLN AVE 21217		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9654 Gunshot Wound of Chest (unspecified) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>			21b. TIME OF INJURY HOUR MONTH DAY YEAR 8:32 P.M. 1-3 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was shot		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) alley-rear of		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 644 W. Mosher St., Baltimore, Md.		
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Dennis F. Smyth			TITLE (SPECIFY) Assistant			MEDICAL EXAMINER DATE SIGNED 1-4-84	
EXAMINER'S NAME (TYPE OR PRINT) F Dennis F. Smyth, M.D.			ADDRESS 111 Penn Street				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 4/10/84		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM PK		23d. LOCATION CITY OR TOWN COUNTY STATE ARBUTUS BALTO Co. MD
24. FUNERAL DIRECTOR NAME JOSEPH L. Russ			ADDRESS 3022 W. NORTH AVE		25a. DATE REC'D. BY REGISTRAR JAN 12 1984		25b. REGISTRAR'S SIGNATURE John J. Connel



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Leroy Walter Cramblitt</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>1-11-84</i>		2b. HOUR <i>10:10 P.M.</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5-31-1907</i>	
6. AGE (IN YEARS (LAST BIRTHDAY)) <i>76</i>		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>6128 Marlona Road -21239</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Book Keeper - Retired Lee Electrai</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Cramblitt</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Florence G. Richards</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>212-07-8495</i>		17. INFORMANT ADDRESS <i>Mrs. Evelyn E. Cramblitt - 6128 Marlona Rd.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4292 Atherosclerotic</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>cardio vascular</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>disease</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>many years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Diabetes mellitus</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>4/24 81 to 1/11 84</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>9/9 82</i> to <i>1/11 84</i> , that (I) (we) last saw the deceased alive on <i>9/9 82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (not) (did) not view the body after death.					
22b. SIGNATURE <i>Samuel Chast</i>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <i>7600 Oiler Drive 2204</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1-14-83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cem.</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md. -21206</i>		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE <i>John J. Smith</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>John C. Miller Inc. 415 Belair Rd. -21206</i>					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18, report any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR						84 00875					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Vernon E. Creek						2a. DATE OF DEATH MONTH DAY YEAR 1-15-84				2b. HOUR M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2-17-35		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD.					
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) bus driver		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY Baltimore		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13. STREET ADDRESS / ZIP CODE 210 Elizabeth Ave. 21225			
14. FATHER'S NAME FIRST MIDDLE LAST John Vernon Creek						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Greene Creek					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 212-30-5290		17. INFORMANT ADDRESS Dorothy Creek 210 Elizabeth Ave. 21225							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>cause unknown (by report of Sinai Hospital ER)</u> DUE TO, OR AS A CONSEQUENCE OF <u>physicians attribute inferior myocardial infarction suggested</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>severe coronary atherosclerosis of heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>1. hypertension 2. chronic PVS's 3. peptic ulcer disease 4. severe peripheral vascular disease 5. hypoparathyroidism by history</u>											
19a. DATE OF OPERATION coronary artery bypass surgery (1978)				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED unstable angina (1978)				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CRYSTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>August</u> 19 <u>82</u> , to <u>December</u> 19 <u>83</u> , that (I) (we) lost saw the deceased above <u>Dec. 23</u> 19 <u>83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Marlene Jaro				DEGREE				22c. DATE SIGNED 1/16/84		22d. ADDRESS Loch Raven VA Hospital Baltimore MD.	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DR. MARLENE JARO											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-20-84		23c. NAME OF CEMETERY OR CREMATORY Mount Calvary CEM.				23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn AA MD.	
24. FUNERAL DIRECTOR NAME Chas. A. Rice FSPA 1300 Eutaw Place						25a. DATE REC'D. BY REGISTRAR JAN 19 1984		25b. REGISTRAR'S SIGNATURE John J. Carver			

1-1-01

SECRET

SECRET

1-1-01

SECRET

SECRET

SECRET

SECRET

1-1-01

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

1-1-01

SECRET

SECRET

SECRET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The physician retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WALTER E. CRISMER			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 5, 1984		2b. HOUR 12:45am			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 6, 1915		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. 68		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Builder-Investments		
12b. KIND OF BUSINESS OR INDUSTRY Construction								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. COUNTY Baltimore		13d. CITY OR TOWN Catonsville		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13f. STREET ADDRESS / ZIP CODE 5449 Wilkens Avenue 21228								
14. FATHER'S NAME FIRST MIDDLE LAST Walter J. Crismer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Gale Woods					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-01-5140		17. INFORMANT Mrs. Rolendis C. Crismer			ADDRESS Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 4241 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Endocarditis, Aortic Valve Replacement, Respiratory Insufficiency								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from November 9, 1983 to 1/5 19 84 , that (I) (we) last saw the deceased alive on 1/5 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Henry Parkman		22c. ADDRESS Johns Hopkins Hospital		22d. DATE SIGNED 1/5/84		22e. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Henry Parkman								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/9/84		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Md.		
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke				25a. DATE REC'D. BY REGISTRAR JAN 6 1984		25b. REGISTRAR'S SIGNATURE John J. Caw		
1630 Edmondson Avenue, Catonsville, Md. 21228								

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) OSBURY E. CROCKETT SR.			2a. DATE OF DEATH MONTH 1 DAY 7 YEAR 84			2b. HOUR 2:15 A.M.	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH 1 DAY 9 YEAR 33		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Eugene MIDDLE LAST Crockett		15. MOTHER'S MAIDEN NAME FIRST Hattie MIDDLE LAST Veney		13e. STREET ADDRESS 5242 Linden Heights Avenue			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 216-30-9829		17. INFORMANT Osbury Crockett Jr. 8876 Fontana Lane			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) CARDIAC ARREST		1 hour
DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA -		3 days
DUE TO, OR AS A CONSEQUENCE OF (c) DIABETIC KETO ACIDOSIS		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

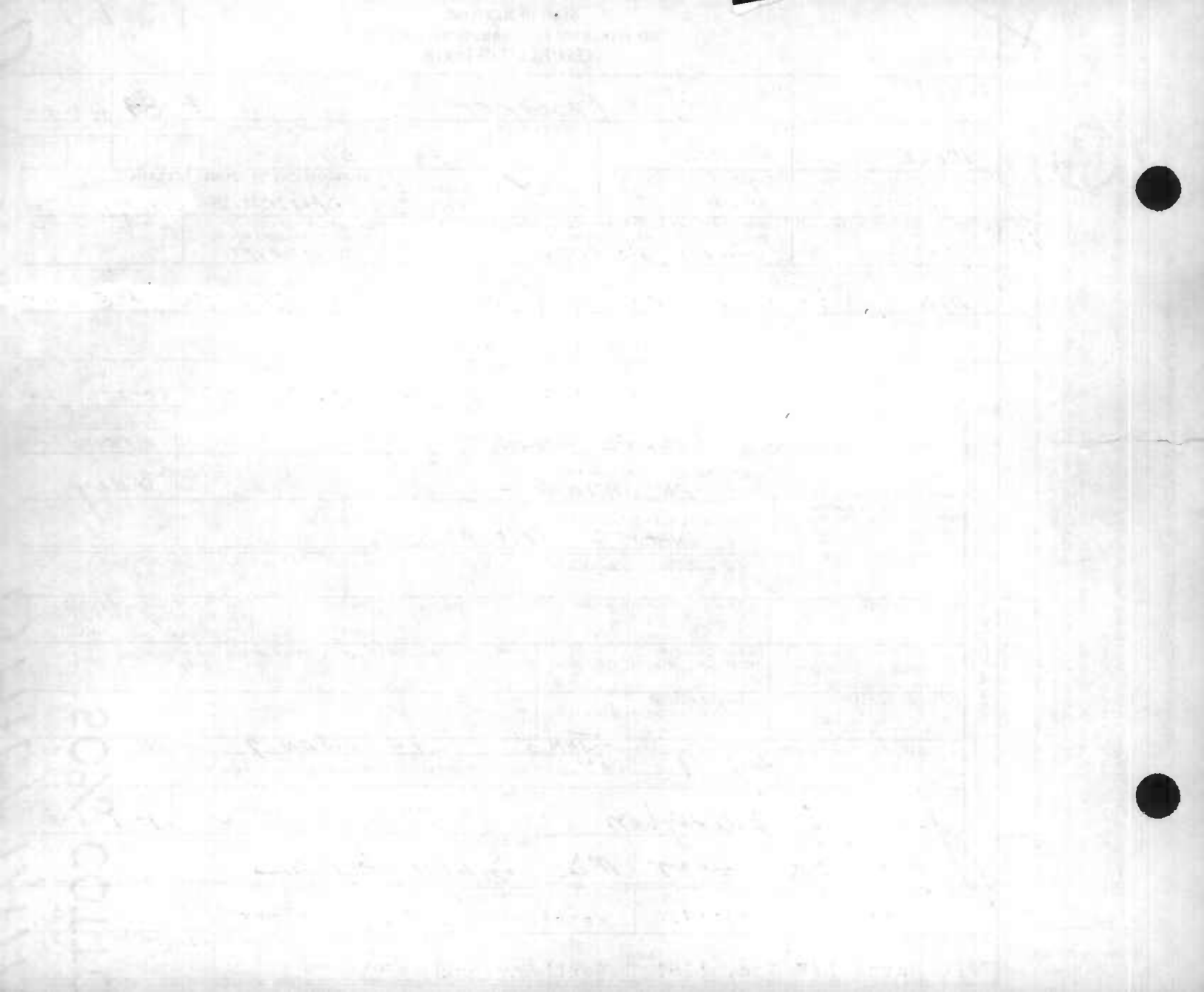
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JAN 5 , 19 84 , to JAN 7 , 19 84 , that (I) (we) last saw the deceased alive on JAN 7 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Penelope & Cunningham				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-7-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PENELOPE SCOTT MD.				22e. ADDRESS SINAI HOSPITAL			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/11/84		23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc. 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR JAN 11 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Signed may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. If item 21 is marked as "I", it shows any injury, or other traumatic event, the medical examiner will be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Claude					2a. DATE OF DEATH MONTH DAY YEAR 1 10 84					2b. HOUR 7:35 AM
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 25 01		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2326 E. Hoffman St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2326 E. Hoffman St. 21213		
14. FATHER'S NAME FIRST MIDDLE LAST Doug Crowell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Henrietta Crowell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-10-1024		17. INFORMANT ADDRESS Brenda Crowell 2326 E. Hoffman Street						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Arterio Sclerotic Cardiovascular Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant 5 mo - 1 yr -										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6-28-83 to present 19 84 , that (I) (we) <input checked="" type="checkbox"/> saw the deceased alive on 6-28-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <input checked="" type="checkbox"/> (did not) view the body after death.										
22b. SIGNATURE Eugene H. Owens					DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-10-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eugene H. Owens					22e. ADDRESS 1735 E Federal St.					
23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL			23b. DATE 1/14/84		23c. NAME OF CEMETERY OR CREMATORY Mount Zion Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Lansdowne, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H 1101 E. North Ave.					25a. DATE REC'D. BY REGISTRAR JAN 11 1984		25b. REGISTRAR'S SIGNATURE John J. Connel			

MEDICAL CERTIFICATION

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

Item #5 Film #G587
FOR STATE 1/24/84 jp
REGISTRAR also item #10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) GERMAINE F. CULVER			2a DATE OF DEATH MONTH DAY YEAR JAN. 9, 1984			2b HOUR 6:00 AM						
3 SEX M		4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR APRIL 25, 1909		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) GA.		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.						
10 CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1001 WHEELER AVE.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GOV. EMPLOY			12b KIND OF BUSINESS OR INDUSTRY			
13a STATE MARYLAND				13b COUNTY		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 21216 1001 WHEELER AVE.		
14 FATHER'S NAME FIRST MIDDLE LAST ALEXANDER CULVER				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY DANIELS								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b SOCIAL SECURITY NO. SWILL		17 INFORMANT ADDRESS ELIZABETH CULVER-1001 WHEELER						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio arrest 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 7-16 19 83, to 1-9 19 84, that (I) (we) lost saw the deceased alive on 7-16 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE Nicholas J. Fortuin MD						DEGREE MD			22c. DATE SIGNED 1-10-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nicholas J. Fortuin						22e ADDRESS 9 Ellman St- Baltimore Md 21202						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 12 JAN 84		23c NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL			23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE Md.				
24 FUNERAL DIRECTOR NAME WM S. GIBSON						ADDRESS 1631 DRUID HILL		25a DATE REC'D. BY REGISTRAR JAN 13 1984		25b REGISTRAR'S SIGNATURE John J. Carver		



[Faint, mostly illegible handwriting in the upper section of the page.]

10 years
A.
+

1907
P. 32
J.
P. 32
J.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury or other trauma that caused or contributed to the death.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
JOHN HENRY CURTIS				JANUARY 27, 1984				6:50A _M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Black		MONTH 1 DAY 8 YEAR 26		57		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MD		USA				BALTIMORE CITY MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		THE JOHNS HOPKINS HOSPITAL									
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
MD						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2716 Fenwick Ave. 21218	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
John H. Curtis				Emma Lewis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Yes				220-18-6267		Maria Dorsey		2312 Loretta Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cardiac Arrest											
4148											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.											
Myocardial Ischemia, Metabolic Acidosis, Renal Failure, Liver Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED							
		HOUR A.M. MONTH DAY YEAR		P.M. 19		(ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/26 19 84 to 1/27 19 84, that (I) (we) last saw the deceased alive on 1/22 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Henry P. Partman								1/27/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Henry Partman				Johns Hopkins Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		2/1/84		Garrison Forest VA		Owings Mills		MD			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Wm. C. March F/H 1101 E. North Ave.				JAN 31 1984				John J. Conner			

20 15 005 0

10000

10000-10

Continued

X

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 8 1

1- FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GARY David CUSTER		2a. DATE OF DEATH MONTH DAY YEAR JANUARY 25, 1984	
2b. HOUR P 11:00 AM			
3. SEX Male		4. RACE White	
5. DATE OF BIRTH MONTH DAY YEAR Dec. 9, 1958		6. AGE (IN YEARS LAST BIRTHDAY) 25 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8. CITIZEN OF WHAT COUNTRY? U.S.A.	
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		10. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Builder	
12b. KIND OF BUSINESS OR INDUSTRY Construction			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Balto. Reisterstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Francis Gene Custer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Deavers	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes NO 1981		16b. SOCIAL SECURITY NO. 218-70-0916	
17. INFORMANT ADDRESS Francis G. Custer 1935 Ridge Road, Reisterstown, Md. 21136			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 0543 HERPES ENCEPHALITIS DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: GNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
19a. DATE OF OPERATION 1/16/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SEMI-COMA	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/16, 1984, to 1/25, 1984, that (I) (we) lost saw the deceased alive on 1/25, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE S. C. MARIA	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) S. C. MARIA		22d. ADDRESS MEYER 5-108 Johns Hopkins Hosp.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 28, 1984	
23c. NAME OF CEMETERY OR CREMATORY Good Shepherd Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR H. E. Eckhardt		25a. DATE REC'D. BY REGISTRAR JAN 30 1984	

3

500

Analysis

• • •

2001, 2002

25

position

• 68

• 02129

DELLS

Table 1

• 54 • 中国书画函授大学肇庆分校建校二十周年纪念册

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 8 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CATHERINE CUSTIS			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 18, 1984			2b. HOUR 11:30AM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 04 23		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. UNDER 1 YEAR MONTHS DAYS 11 18	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Dee Williams			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucinda Powell			16. STREET ADDRESS / ZIP CODE 1656 E. Belvedere Avenue 21239			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-24-3845		17. INFORMANT ADDRESS Floyd H. Curtis 1656 E. Belvedere Avenue				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 1809 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC CERVICAL CANCER APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from JAN 14, 19 84 to JAN 18, 19 84 , that (I) (we) last saw the deceased alive on JAN 18, 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M. Bohrer			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/18/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M BOHRER, MD			22e. ADDRESS JOHNS HOPKINS HOSPITAL						
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL			23b. DATE 1/23/84		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Md		
24. FUNERAL DIRECTOR NAME William C March F/H Inc.			ADDRESS 1101 E North Avenue			25a. DATE RECEIVED BY REGISTRAR JAN 20 1984		25b. REGISTRAR'S SIGNATURE John J. Bohrer	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2

INDEX

DOWN

RECEIVED
JAN 10 1960

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Grace M. Cuthbertson			1 8 84			9 A M		
3. SEX			4. RACE			5. DATE OF BIRTH		
Female			White			2 7 1904		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
Tennessee			U.S.A.			9. BALTIMORE CITY OR COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Baltimore			Baltimore City Hospital			Sales Clerk		
12b. KIND OF BUSINESS OR INDUSTRY			13a. STREET ADDRESS / ZIP CODE			13b. INSIDE CITY LIMITS?		
May Co.			2019 Paulette Road 21222			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
John C. Akins			Ellen I. Johnson			16b. SOCIAL SECURITY NO.		
						241-05-7046		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Ruby Morrison			PART 1. DEATH WAS CAUSED BY:			1 HR		
			IMMEDIATE CAUSE (a) <i>myocardial infarction</i>					
			DUE TO, OR AS A CONSEQUENCE OF					
			(b) <i>coronary insufficiency</i>			5 YRS		
			DUE TO, OR AS A CONSEQUENCE OF					
			(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		
Diabetes mellitus								
20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
			HOUR A.M. MONTH DAY YEAR					
			P.M. 19					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION		
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 19 17, 19 83, to 11 8, 19 84, that (I) (we) lost saw the deceased alive on 11-21-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			22b. SIGNATURE			22c. DATE SIGNED		
			Paul G. Herold M.D.			1/9/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
P. G. Herold, M.D.			10 W. Madison Avenue, Balto. MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			1/12/84			Oak Grove Cem.		
23d. LOCATION			23e. REGISTRAR'S SIGNATURE			23f. DATE REC'D. BY REGISTRAR		
Rockwood			John G. Herold			JAN 1 3 1984		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
NAME Duda-Ruck, Inc. ADDRESS			7922 Wise Avenue, Dundalk, MD 21222					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Registrar should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use in the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

A P

MADE IN HONG KONG

MADE IN HONG KONG

118

252

MADE IN HONG KONG

MADE IN HONG KONG

MADE IN HONG KONG

118

118

118

118

118

11/11/11

MADE IN HONG KONG

MADE IN HONG KONG

MADE IN HONG KONG

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 8 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Aleksander ALEKSANDER - Czaplinski CZAPLINSKI		2a. DATE OF DEATH MONTH DAY YEAR January 6, 1984		2b. HOUR 6:20 P. M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 15, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS
7a. BIRTHPLACE (COUNTRY) Glasgow, Scotland	7b. CITIZEN OF WHAT COUNTRY? Great Britain	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 101 N. Highland Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steel Worker	12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel
13a. STATE Md.		13b. COUNTY ---	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph -- Czaplinski		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nicholina -- Kraska		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-28-1537		17. INFORMANT ADDRESS Baltimore, Md. 21224. Brian R. Czaplinski-101 N. Highland Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Lung (c) ---				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 1 yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 9/81 , 19 81 , to 1/6 , 19 84 , that (I) (we) lost saw the deceased alive on 12/83 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE Mark G. Midei MD		DEGREE MD		22c. DATE SIGNED 1/7/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Midei		22e. ADDRESS 601 N. Wolfe, Baltimore, MD 21205		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/9/84	23c. NAME OF CEMETERY OR CREMATORY Holy Trinity Rus.Orth. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE -Howard Cty., Md.
24. FUNERAL DIRECTOR NAME John A. Moran, Inc.		ADDRESS 3000 E. Baltimore Street, Btlo., Md. 21224		DATE REC'D. BY REGISTRAR JAN 9 1984
25a. REGISTRAR'S SIGNATURE San J. Cawich				25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

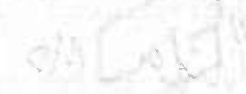
EX-105



18/8

18/8

18/8



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8400885

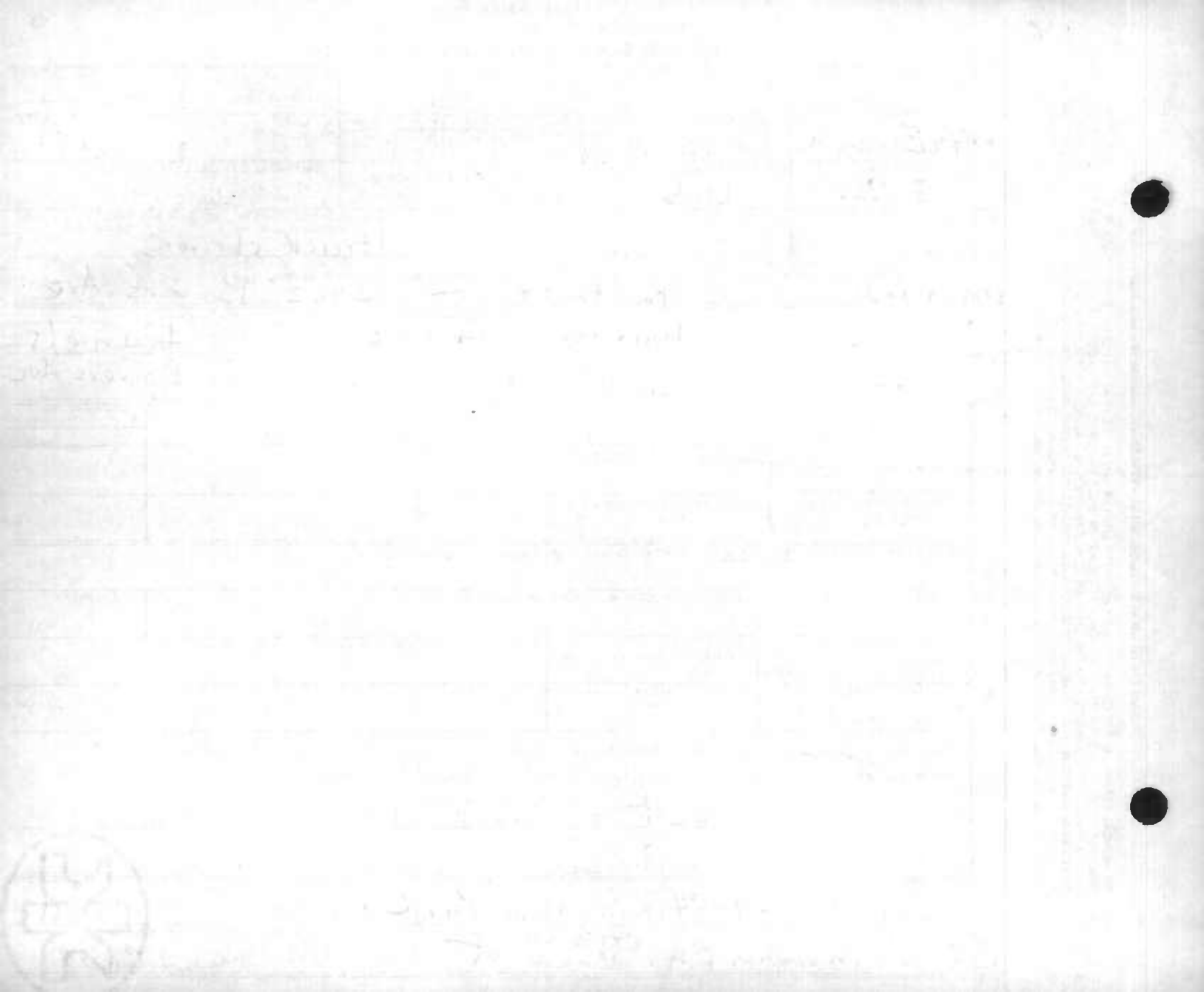
1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Mildred G. Danhower		2a. DATE OF DEATH MONTH DAY YEAR Jan. 27, 1984	
3. SEX Female		2b. HOUR 2:00 Am	
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 3, 1911	
6. AGE (IN YEARS LAST BIRTHDAY) 72		7. UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Garment	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD.		13b. COUNTY Balto.	
13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Elias B. Pegg		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Davis	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 1231 Cross St. Balto. 21230	
17. INFORMANT Bobby F. Brown		ADDRESS 1231 Cross St. Balto. 21230	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4920 DUE TO, OR AS A CONSEQUENCE OF EMPHYSEMA (b) Tumor of lung DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
21g. DATE OF OPERATION		21h. DATE OF OPERATION	
21i. DATE OF OPERATION		21j. DATE OF OPERATION	
21k. DATE OF OPERATION		21l. DATE OF OPERATION	
21m. DATE OF OPERATION		21n. DATE OF OPERATION	
21o. DATE OF OPERATION		21p. DATE OF OPERATION	
21q. DATE OF OPERATION		21r. DATE OF OPERATION	
21s. DATE OF OPERATION		21t. DATE OF OPERATION	
21u. DATE OF OPERATION		21v. DATE OF OPERATION	
21w. DATE OF OPERATION		21x. DATE OF OPERATION	
21y. DATE OF OPERATION		21z. DATE OF OPERATION	
21aa. DATE OF OPERATION		21ab. DATE OF OPERATION	
21ac. DATE OF OPERATION		21ad. DATE OF OPERATION	
21ae. DATE OF OPERATION		21af. DATE OF OPERATION	
21ag. DATE OF OPERATION		21ah. DATE OF OPERATION	
21ai. DATE OF OPERATION		21aj. DATE OF OPERATION	
21ak. DATE OF OPERATION		21al. DATE OF OPERATION	
21am. DATE OF OPERATION		21an. DATE OF OPERATION	
21ao. DATE OF OPERATION		21ap. DATE OF OPERATION	
21aq. DATE OF OPERATION		21ar. DATE OF OPERATION	
21as. DATE OF OPERATION		21at. DATE OF OPERATION	
21au. DATE OF OPERATION		21av. DATE OF OPERATION	
21aw. DATE OF OPERATION		21ax. DATE OF OPERATION	
21ay. DATE OF OPERATION		21az. DATE OF OPERATION	
21ba. DATE OF OPERATION		21bb. DATE OF OPERATION	
21bc. DATE OF OPERATION		21bd. DATE OF OPERATION	
21be. DATE OF OPERATION		21bf. DATE OF OPERATION	
21bg. DATE OF OPERATION		21bh. DATE OF OPERATION	
21bi. DATE OF OPERATION		21bj. DATE OF OPERATION	
21bk. DATE OF OPERATION		21bl. DATE OF OPERATION	
21bm. DATE OF OPERATION		21bn. DATE OF OPERATION	
21bo. DATE OF OPERATION		21bp. DATE OF OPERATION	
21bq. DATE OF OPERATION		21br. DATE OF OPERATION	
21bs. DATE OF OPERATION		21bt. DATE OF OPERATION	
21bu. DATE OF OPERATION		21bv. DATE OF OPERATION	
21bw. DATE OF OPERATION		21bx. DATE OF OPERATION	
21by. DATE OF OPERATION		21bz. DATE OF OPERATION	
21ca. DATE OF OPERATION		21cb. DATE OF OPERATION	
21cc. DATE OF OPERATION		21cd. DATE OF OPERATION	
21ce. DATE OF OPERATION		21cf. DATE OF OPERATION	
21cg. DATE OF OPERATION		21ch. DATE OF OPERATION	
21ci. DATE OF OPERATION		21cj. DATE OF OPERATION	
21ck. DATE OF OPERATION		21cl. DATE OF OPERATION	
21cm. DATE OF OPERATION		21cn. DATE OF OPERATION	
21co. DATE OF OPERATION		21cp. DATE OF OPERATION	
21cq. DATE OF OPERATION		21cr. DATE OF OPERATION	
21cs. DATE OF OPERATION		21ct. DATE OF OPERATION	
21cu. DATE OF OPERATION		21cv. DATE OF OPERATION	
21cw. DATE OF OPERATION		21cx. DATE OF OPERATION	
21cy. DATE OF OPERATION		21cz. DATE OF OPERATION	
21da. DATE OF OPERATION		21db. DATE OF OPERATION	
21dc. DATE OF OPERATION		21dd. DATE OF OPERATION	
21de. DATE OF OPERATION		21df. DATE OF OPERATION	
21dg. DATE OF OPERATION		21dh. DATE OF OPERATION	
21di. DATE OF OPERATION		21dj. DATE OF OPERATION	
21dk. DATE OF OPERATION		21dl. DATE OF OPERATION	
21dm. DATE OF OPERATION		21dn. DATE OF OPERATION	
21do. DATE OF OPERATION		21dp. DATE OF OPERATION	
21dq. DATE OF OPERATION		21dr. DATE OF OPERATION	
21ds. DATE OF OPERATION		21dt. DATE OF OPERATION	
21du. DATE OF OPERATION		21dv. DATE OF OPERATION	
21dw. DATE OF OPERATION		21dx. DATE OF OPERATION	
21dy. DATE OF OPERATION		21dz. DATE OF OPERATION	
21ea. DATE OF OPERATION		21eb. DATE OF OPERATION	
21ec. DATE OF OPERATION		21ed. DATE OF OPERATION	
21ee. DATE OF OPERATION		21ef. DATE OF OPERATION	
21eg. DATE OF OPERATION		21eh. DATE OF OPERATION	
21ei. DATE OF OPERATION		21ej. DATE OF OPERATION	
21ek. DATE OF OPERATION		21el. DATE OF OPERATION	
21em. DATE OF OPERATION		21en. DATE OF OPERATION	
21eo. DATE OF OPERATION		21ep. DATE OF OPERATION	
21eq. DATE OF OPERATION		21er. DATE OF OPERATION	
21es. DATE OF OPERATION		21et. DATE OF OPERATION	
21eu. DATE OF OPERATION		21ev. DATE OF OPERATION	
21ew. DATE OF OPERATION		21ex. DATE OF OPERATION	
21ey. DATE OF OPERATION		21ez. DATE OF OPERATION	
21fa. DATE OF OPERATION		21fb. DATE OF OPERATION	
21fc. DATE OF OPERATION		21fd. DATE OF OPERATION	
21fe. DATE OF OPERATION		21ff. DATE OF OPERATION	
21fg. DATE OF OPERATION		21fh. DATE OF OPERATION	
21fi. DATE OF OPERATION		21fj. DATE OF OPERATION	
21fk. DATE OF OPERATION		21fl. DATE OF OPERATION	
21fm. DATE OF OPERATION		21fn. DATE OF OPERATION	
21fo. DATE OF OPERATION		21fp. DATE OF OPERATION	
21fq. DATE OF OPERATION		21fr. DATE OF OPERATION	
21fs. DATE OF OPERATION		21ft. DATE OF OPERATION	
21fu. DATE OF OPERATION		21fv. DATE OF OPERATION	
21fw. DATE OF OPERATION		21fx. DATE OF OPERATION	
21fy. DATE OF OPERATION		21fz. DATE OF OPERATION	
21ga. DATE OF OPERATION		21gb. DATE OF OPERATION	
21gc. DATE OF OPERATION		21gd. DATE OF OPERATION	
21ge. DATE OF OPERATION		21gf. DATE OF OPERATION	
21gg. DATE OF OPERATION		21gh. DATE OF OPERATION	
21gi. DATE OF OPERATION		21gj. DATE OF OPERATION	
21gk. DATE OF OPERATION		21gl. DATE OF OPERATION	
21gm. DATE OF OPERATION		21gn. DATE OF OPERATION	
21go. DATE OF OPERATION		21gp. DATE OF OPERATION	
21gq. DATE OF OPERATION		21gr. DATE OF OPERATION	
21gs. DATE OF OPERATION		21gt. DATE OF OPERATION	
21gu. DATE OF OPERATION		21gv. DATE OF OPERATION	
21gw. DATE OF OPERATION		21gx. DATE OF OPERATION	
21gy. DATE OF OPERATION		21gz. DATE OF OPERATION	
21ha. DATE OF OPERATION		21hb. DATE OF OPERATION	
21hc. DATE OF OPERATION		21hd. DATE OF OPERATION	
21he. DATE OF OPERATION		21hf. DATE OF OPERATION	
21hg. DATE OF OPERATION		21hh. DATE OF OPERATION	
21hi. DATE OF OPERATION		21hj. DATE OF OPERATION	
21hk. DATE OF OPERATION		21hl. DATE OF OPERATION	
21hm. DATE OF OPERATION		21hn. DATE OF OPERATION	
21ho. DATE OF OPERATION		21hp. DATE OF OPERATION	
21hq. DATE OF OPERATION		21hr. DATE OF OPERATION	
21hs. DATE OF OPERATION		21ht. DATE OF OPERATION	
21hu. DATE OF OPERATION		21hv. DATE OF OPERATION	
21hw. DATE OF OPERATION		21hx. DATE OF OPERATION	
21hy. DATE OF OPERATION		21hz. DATE OF OPERATION	
21ia. DATE OF OPERATION		21ib. DATE OF OPERATION	
21ic. DATE OF OPERATION		21id. DATE OF OPERATION	
21ie. DATE OF OPERATION		21if. DATE OF OPERATION	
21ig. DATE OF OPERATION		21ih. DATE OF OPERATION	
21ii. DATE OF OPERATION		21ij. DATE OF OPERATION	
21ik. DATE OF OPERATION		21il. DATE OF OPERATION	
21im. DATE OF OPERATION		21in. DATE OF OPERATION	
21io. DATE OF OPERATION		21ip. DATE OF OPERATION	
21iq. DATE OF OPERATION		21ir. DATE OF OPERATION	
21is. DATE OF OPERATION		21it. DATE OF OPERATION	
21iu. DATE OF OPERATION		21iv. DATE OF OPERATION	
21iw. DATE OF OPERATION		21ix. DATE OF OPERATION	
21iy. DATE OF OPERATION		21iz. DATE OF OPERATION	
21ja. DATE OF OPERATION		21jb. DATE OF OPERATION	
21jc. DATE OF OPERATION		21jd. DATE OF OPERATION	
21je. DATE OF OPERATION		21jf. DATE OF OPERATION	
21jg. DATE OF OPERATION		21jh. DATE OF OPERATION	
21ji. DATE OF OPERATION		21jj. DATE OF OPERATION	
21jk. DATE OF OPERATION		21jl. DATE OF OPERATION	
21jm. DATE OF OPERATION		21jn. DATE OF OPERATION	
21jo. DATE OF OPERATION		21jp. DATE OF OPERATION	
21jq. DATE OF OPERATION		21jr. DATE OF OPERATION	
21js. DATE OF OPERATION		21jt. DATE OF OPERATION	
21ju. DATE OF OPERATION		21jv. DATE OF OPERATION	
21jw. DATE OF OPERATION		21jx. DATE OF OPERATION	
21jy. DATE OF OPERATION		21jz. DATE OF OPERATION	
21ka. DATE OF OPERATION		21kb. DATE OF OPERATION	
21kc. DATE OF OPERATION		21kd. DATE OF OPERATION	
21ke. DATE OF OPERATION		21kf. DATE OF OPERATION	
21kg. DATE OF OPERATION		21kh. DATE OF OPERATION	
21ki. DATE OF OPERATION		21kj. DATE OF OPERATION	
21kk. DATE OF OPERATION		21kl. DATE OF OPERATION	
21km. DATE OF OPERATION		21kn. DATE OF OPERATION	
21ko. DATE OF OPERATION		21kp. DATE OF OPERATION	
21kq. DATE OF OPERATION		21kr. DATE OF OPERATION	
21ks. DATE OF OPERATION		21kt. DATE OF OPERATION	
21ku. DATE OF OPERATION		21kv. DATE OF OPERATION	
21kw. DATE OF OPERATION		21kx. DATE OF OPERATION	
21ky. DATE OF OPERATION		21kz. DATE OF OPERATION	
21la. DATE OF OPERATION		21lb. DATE OF OPERATION	
21lc. DATE OF OPERATION		21ld. DATE OF OPERATION	
21le. DATE OF OPERATION		21lf. DATE OF OPERATION	
21lg. DATE OF OPERATION		21lh. DATE OF OPERATION	
21li. DATE OF OPERATION		21lj. DATE OF OPERATION	
21lk. DATE OF OPERATION		21ll. DATE OF OPERATION	
21lm. DATE OF OPERATION		21ln. DATE OF OPERATION	
21lo. DATE OF OPERATION		21lp. DATE OF OPERATION	
21lq. DATE OF OPERATION		21lr. DATE OF OPERATION	
21ls. DATE OF OPERATION		21lt. DATE OF OPERATION	
21lu. DATE OF OPERATION		21lv. DATE OF OPERATION	
21lw. DATE OF OPERATION		21lx. DATE OF OPERATION	
21ly. DATE OF OPERATION		21lz. DATE OF OPERATION	
21ma. DATE OF OPERATION		21mb. DATE OF OPERATION	
21mc. DATE OF OPERATION		21md. DATE OF OPERATION	
21me. DATE OF OPERATION		21mf. DATE OF OPERATION	
21mg. DATE OF OPERATION		21mh. DATE OF OPERATION	
21mi. DATE OF OPERATION		21mj. DATE OF OPERATION	
21mk. DATE OF OPERATION		21ml. DATE OF OPERATION	
21mm. DATE OF OPERATION		21mn. DATE OF OPERATION	
21mo. DATE OF OPERATION		21mp. DATE OF OPERATION	
21mq. DATE OF OPERATION		21mr. DATE OF OPERATION	
21ms. DATE OF OPERATION		21mt. DATE OF OPERATION	
21mu. DATE OF OPERATION		21mv. DATE OF OPERATION	
21mw. DATE OF OPERATION		21mx. DATE OF OPERATION	
21my. DATE OF OPERATION		21mz. DATE OF OPERATION	
21na. DATE OF OPERATION		21nb. DATE OF OPERATION	
21nc. DATE OF OPERATION		21nd. DATE OF OPERATION	
21ne. DATE OF OPERATION		21nf. DATE OF OPERATION	
21ng. DATE OF OPERATION		21nh. DATE OF OPERATION	
21ni. DATE OF OPERATION		21nj. DATE OF OPERATION	
21nk. DATE OF OPERATION		21nl. DATE OF OPERATION	
21nm. DATE OF OPERATION		21nn. DATE OF OPERATION	
21no. DATE OF OPERATION		21np. DATE OF OPERATION	
21nq. DATE OF OPERATION		21nr. DATE OF OPERATION	
21ns. DATE OF OPERATION		21nt. DATE OF OPERATION	
21nu. DATE OF OPERATION		21nv. DATE OF OPERATION	
21nw. DATE OF OPERATION		21nx. DATE OF OPERATION	
21ny. DATE OF OPERATION		21nz. DATE OF OPERATION	
21oa. DATE OF OPERATION		21ob. DATE OF OPERATION	
21oc. DATE OF OPERATION		21od. DATE OF OPERATION	
21oe. DATE OF OPERATION		21of. DATE OF OPERATION	
21og. DATE OF OPERATION		21oh. DATE OF OPERATION	
21oi. DATE OF OPERATION		21oj. DATE OF OPERATION	
21ok. DATE OF OPERATION		21ol. DATE OF OPERATION	
21om. DATE OF OPERATION		21on. DATE OF OPERATION	
21oo. DATE OF OPERATION		21op. DATE OF OPERATION	
21oq. DATE OF OPERATION		21or. DATE OF OPERATION	
21os. DATE OF OPERATION		21ot. DATE OF OPERATION	
21ou. DATE OF OPERATION		21ov. DATE OF OPERATION	
21ow. DATE OF OPERATION		21ox. DATE OF OPERATION	
21oy. DATE OF OPERATION		21oz. DATE OF OPERATION	
21pa. DATE OF OPERATION		21pb. DATE OF OPERATION	
21pc. DATE OF OPERATION		21pd. DATE OF OPERATION	
21pe. DATE OF OPERATION		21pf. DATE OF OPERATION	
21pg. DATE OF OPERATION		21ph. DATE OF OPERATION	
21pi. DATE OF OPERATION		21pj. DATE OF OPERATION	
21pk. DATE OF OPERATION		21pl. DATE OF OPERATION	
21pm. DATE OF OPERATION		21pn. DATE OF OPERATION	
21po. DATE OF OPERATION		21pp. DATE OF OPERATION	
21pq. DATE OF OPERATION		21pr. DATE OF OPERATION	
21ps. DATE OF OPERATION		21pt. DATE OF OPERATION	
21pu. DATE OF OPERATION		21pv. DATE OF OPERATION	
21pw. DATE OF OPERATION		21px. DATE OF OPERATION	
21py. DATE OF OPERATION		21pz. DATE OF OPERATION	
21qa. DATE OF OPERATION		21qb. DATE OF OPERATION	
21qc. DATE OF OPERATION		21qd. DATE OF OPERATION	
21qe. DATE OF OPERATION		21qf. DATE OF OPERATION	
21qg. DATE OF OPERATION		21qh. DATE OF OPERATION	
21qi. DATE OF OPERATION		21qj. DATE OF OPERATION	
21qk. DATE OF OPERATION		21ql. DATE OF OPERATION	
21qm. DATE OF OPERATION		21qn. DATE OF OPERATION	
21qo. DATE OF OPERATION		21qp. DATE OF OPERATION	
21qq. DATE OF OPERATION		21qr. DATE OF OPERATION	
21qs. DATE OF OPERATION		21qt. DATE OF OPERATION	
21qu. DATE OF OPERATION		21qv. DATE OF OPERATION	
21qw. DATE OF OPERATION		21qx. DATE OF OPERATION	
21qy. DATE OF OPERATION		21qz. DATE OF OPERATION	
21ra. DATE OF OPERATION		21rb. DATE OF OPERATION	
21rc. DATE OF OPERATION		21rd. DATE OF OPERATION	
21re. DATE OF OPERATION		21rf. DATE OF OPERATION	
21rg. DATE OF OPERATION		21rh. DATE OF OPERATION	
21ri. DATE OF OPERATION		21rj. DATE OF OPERATION	
21rk. DATE OF OPERATION		21rl. DATE OF OPERATION	
21rm. DATE OF OPERATION		21rn. DATE OF OPERATION	
21ro. DATE OF OPERATION		21rp. DATE OF OPERATION	
21rq. DATE OF OPERATION		21rr. DATE OF OPERATION	
21rs. DATE OF OPERATION		21rt. DATE OF OPERATION	
21ru. DATE OF OPERATION		21rv. DATE OF OPERATION	
21rw. DATE OF OPERATION		21rx. DATE OF OPERATION	
21ry. DATE OF OPERATION		21rz. DATE OF OPERATION	
21sa. DATE OF OPERATION		21sb. DATE OF OPERATION	
21sc. DATE OF OPERATION		21sd. DATE OF OPERATION	
21se. DATE OF OPERATION		21sf. DATE OF OPERATION	
21sg. DATE OF OPERATION		21sh. DATE OF OPERATION	
21si. DATE OF OPERATION		21sj. DATE OF OPERATION	
21sk. DATE OF OPERATION		21sl. DATE OF OPERATION	
21sm. DATE OF OPERATION		21sn. DATE OF OPERATION	
21so. DATE OF OPERATION		21sp. DATE OF OPERATION	
21sq. DATE OF OPERATION		21sr. DATE OF OPERATION	
21ss. DATE OF OPERATION		21st. DATE OF OPERATION	
21su. DATE OF OPERATION		21sv. DATE OF OPERATION	
21sw. DATE OF OPERATION		21sx. DATE OF OPERATION	
21sy. DATE OF OPERATION		21sz. DATE OF OPERATION	
21ta. DATE OF OPERATION		21tb. DATE OF OPERATION	
21tc. DATE OF OPERATION		21td. DATE OF OPERATION	
21te. DATE OF OPERATION		21tf. DATE OF OPERATION	
21tg. DATE OF OPERATION		21th. DATE OF OPERATION	
21ti. DATE OF OPERATION		21tj. DATE OF OPERATION	
21tk. DATE OF OPERATION		21tl. DATE OF OPERATION	
21tm. DATE OF OPERATION		21tn. DATE OF OPERATION	
21to. DATE OF OPERATION		21tp. DATE OF OPERATION	
21tq. DATE OF OPERATION		21tr. DATE OF OPERATION	
21ts. DATE OF OPERATION		21tt. DATE OF OPERATION	
21tu. DATE OF OPERATION		21tv. DATE OF OPERATION	
21tw. DATE OF OPERATION		21tx. DATE OF OPERATION	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH THE DIVISION OF VITAL RECORDS, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Moses		MIDDLE Daniels		LAST Daniels		20. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 3 19 84 2b. HOUR M 3:40A	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR Sept 15 1917 66 YRS.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 3 1984		2d. HOUR M 3:40A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2902 Bowers Avenue				12a. USUAL OCCUPATION (TYPE OF WORK) truck driver		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2902 Bowers Ave.			
14. FATHER'S NAME FIRST Eugene		MIDDLE Wilson		15. MOTHER'S MAIDEN NAME FIRST Annie		MIDDLE Daniels		LAST Daniels			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-09-2070		17. INFORMANT Susan Daniels		ADDRESS 2902 Bowers Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion										TITLE (SPECIFY) Deputy Chief	
ACTUAL SIGNATURE		EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.		DATE SIGNED 1/3/84		MEDICAL EXAMINER	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-7-84		23c. NAME OF CEMETERY OR CREMATORY King Mem. Park		23d. LOCATION CITY OR TOWN Balto.		COUNTY		STATE md.	
24. FUNERAL DIRECTOR NAME Brown-Thompson F. it.		ADDRESS 1913 W. BACW. ST.		25a. DATE REC'D. BY REGISTRAR JAN 6 1984		25b. REGISTRAR'S SIGNATURE Joan J. Carver					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wilmer Daubert				2a. DATE OF DEATH MONTH DAY YEAR 11/11/84		2b. HOUR 11:00 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 02-6-09		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mount Sinai Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. STATE MD.		13b. COUNTY BALTI.		13c. CITY OR TOWN BALTI.		13d. STREET ADDRESS 2500 BELVEDERE AVE	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES #28999818/00				16b. SOCIAL SECURITY NO. 219-28-3494		17. INFORMANT Blanche Daubert, 2500 W. Belvedere Ave, 21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 4292 ASCVD IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) PARKINSON DISEASE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the medical examiner) attended the deceased from 2-17 , 19 82 , to 1-11 , 19 84 , that I (we) lost saw the deceased alive on 1-11 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE ARTHUR M. VERNON MD PA				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-12-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 3640 FORDS LANE RAND MD 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/17/84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Md.	
24. FUNERAL DIRECTOR NAME Law Funeral Home 4611 Park Heights Ave. 21215				25a. DATE REC'D. BY REGISTRAR JAN 17 1984		25b. REGISTRAR'S SIGNATURE John J. Carver	

BP

DHMH-16 20M
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
BABY GIRL DAUT					1/2/84 905 PM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
FEMALE		WHITE		1 2 84		YRS		31	
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND						BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		UNION MEMORIAL HOSPITAL							
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS / ZIP CODE			
Md.		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1508 Medford Rd. 21218			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
DONALD ROBERT DAUT					JANET WILSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
				MOTHER					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Extreme Prematurity. - 23 3/4 wks by Dates.</u>									
7621 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Possible - Abruptio placentae.</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		Vaginal delivery				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8:35 PM 1/2/1984 to 905 1/2 1984, that (I) (we) last saw the deceased alive on 1/2/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				22c. DATE SIGNED			
<i>S. M. Diddikar</i>						1/2/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
S. M. DIDDIKAR MD		201 E. Univ. Parkway Balto Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. REGISTRAR'S SIGNATURE	
Removal		12/5/83				CITY OR TOWN COUNTY STATE		JAN 12 1984	
24. FUNERAL DIRECTOR NAME					25. DATE REG'D BY REGISTRAR				
Anatomy Board					Balto., Md.				

Handwritten notes or scribbles at the top left of the page.

Handwritten notes or scribbles at the top center of the page.

Handwritten word, possibly "TUE".

Handwritten word, possibly "WED".

Handwritten word, possibly "THU".

Handwritten word, possibly "FRI".

Handwritten text, possibly "THE UNIVERSITY OF".

Handwritten text, possibly "IN THE".

Handwritten text, possibly "THE UNIVERSITY OF".

Handwritten text, possibly "THE UNIVERSITY OF".

Handwritten text, possibly "THE UNIVERSITY OF".

Handwritten text, possibly "THE UNIVERSITY OF".

Handwritten text, possibly "THE UNIVERSITY OF".

Handwritten text, possibly "THE UNIVERSITY OF".

Handwritten text, possibly "THE UNIVERSITY OF".

Handwritten text, possibly "THE UNIVERSITY OF".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

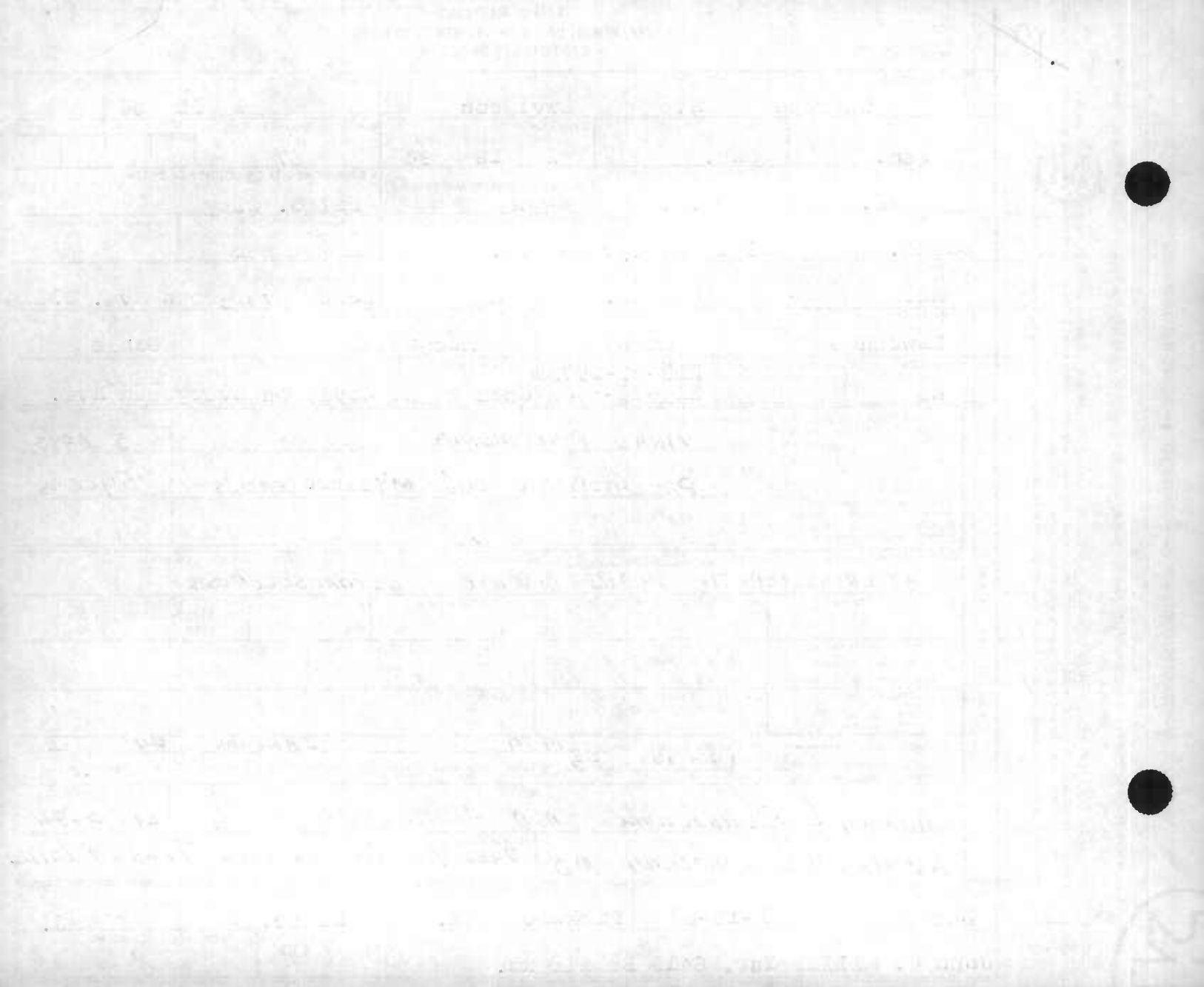
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-355-2848.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Theresa A. Davidson			2a. DATE OF DEATH MONTH DAY YEAR 1 12 84			2b. HOUR M		
3 SEX Fem.		4 RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 1 18 96		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? US.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.		
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2808 1/2 Evergreen Ave.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY -		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence Krebs		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Gable						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 212-07-2973D 214-74-5480		17. INFORMANT ADDRESS Charles E. Davidson Evergreen Ave. 2808 1/2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2848 VIRAL PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) PANCYTOPENIA DUE - MYELOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 5 YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ARTERIOSCLEROTIC HEART DISEASE NEPHROSCLEROSIS								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1979, 19, to JANUARY 1984, that (I) (we) last saw the deceased alive on 12-15-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Anthony A. Lewandowski M.D.				DEGREE M.D.		22c. DATE SIGNED 01-13-84		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) ANTHONY A. LEWANDOWSKI M.D.				22e. ADDRESS 7402 York Rd. Suite 102 Towson Md 21204				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-16-84		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		
24. FUNERAL DIRECTOR NAME John C. Miller Inc. 6415 Belair Rd.				25a. DATE REC'D. BY REGISTRAR JAN 13 1984				
				25b. REGISTRAR'S SIGNATURE John J. Canine				

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician who attended the deceased. The law also requires that the death certificate be signed by the attending physician who attended the deceased. The law also requires that the death certificate be signed by the attending physician who attended the deceased.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the funeral director should be detached for use on the burial transit permit. This permit requires carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 9 0

REG. NO.

DECEASED NAME (TYPE OR PRINT) ADELLA S. DAVIS			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 23, 1984		2b. HOUR 5:42A	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 14 09		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin F. Williams		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Perry		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. 215-12-5656		17. INFORMANT ADDRESS Brenda Graves 2103 E. Lafayette Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Ischemic Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c) coronary artery disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes years years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) metastatic Breast Cancer						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1/18 to 1/23 , 19 84 , that (I) (we) last saw the deceased alive on 1/23 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE KM Carbone MD		DEGREE MD		22c. DATE SIGNED 1/23/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KM Carbone MD		22e. ADDRESS Johns Hopkins Hospital Baltimore				
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 1/28/84		23c. NAME OF CEMETERY OR CREMATORY King Memorial Park		
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc.		ADDRESS 1101 E North Avenue		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown, Md.		
25a. DATE REC'D. BY REGISTRAR JAN 24 1984		25b. REGISTRAR'S SIGNATURE Joan J. Carver				

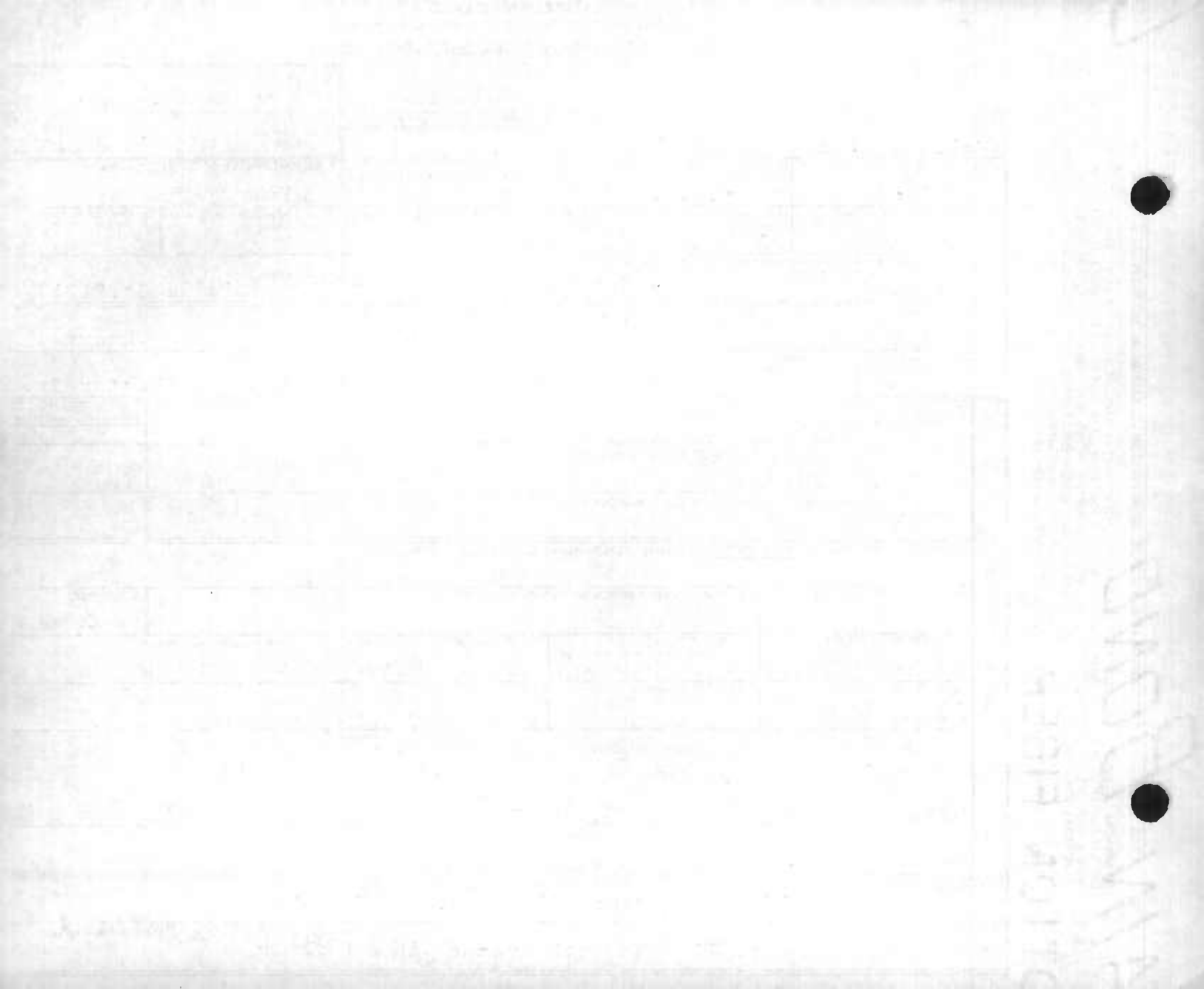
—

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 4 0 0 8 9 1	
1- STATE REGISTRAR UNK.#84-6										MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
1. DECEASED NAME										REG. NO.	
FIRST MIDDLE LAST										2b. DATE KNOWN OF DEATH	
Ernest Davis, Jr.										1-20 1984	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
Male		Black		11 14 29		54 YRS.		MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		2d. HOUR	
Maryland		U.S.A.		WIDOWED		DIVORCED		Baltimore City,		2:15 p.m.	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore				Aliceanne & Fells Sts.-in water							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2215 E. Biddle St. 21213			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Ernest Davis				Nettie Brown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
NO				220-24-2083				Bertha Davis 1836 N. Chester St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Drowning</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				est. YEAR ? P.M. 1-20 1984				subject recovered from water			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				water				Aliceanne & Fells Sts., Baltimore, Md.			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Dennis F. Smyth, M.D.</u> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER								DATE SIGNED		1-22-84	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.								ADDRESS 111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		
BURIAL				1/27/84		Mount Zion Cem.			Lansdowne, Md.		
24. FUNERAL DIRECTOR								25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm C March F/H Inc. 1101 E North Avenue								JAN 27 1984		<u>John J. Smith</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8400392

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROY DAVIS			2a. DATE OF DEATH MONTH DAY YEAR 1-14-84			2b. HOUR 4⁴⁵ PM			
SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 5 1 26		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSPITALS				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 704 Mura Street 21202	
14. FATHER'S NAME FIRST MIDDLE LAST Jessie Lucas				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Pittman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 728-09-3031		17. INFORMANT ADDRESS Mary Davis 1511 Pentridge Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) Arteriosclerotic Disease - arrest cardiac DUE TO, OR AS A CONSEQUENCE OF (b) Coronary heart disease / hypertension 5-10 YRS. DUE TO, OR AS A CONSEQUENCE OF (c) cerebrovascular arteriosclerosis 2 YEARS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Andrew Goldberg			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/15/84	
22d. PHYSICIAN'S NAME (PRINT) ANDREW GOLDBERG			22e. ADDRESS Mason Flord Hospital / Balt. MD 21224						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1/19/84		23c. NAME OF CEMETERY OR CREMATORY Mount Zion Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lansdowne, Md.		
24. FUNERAL DIRECTOR NAME WM. C. March F.H. INC.			ADDRESS 1101 E. North Ave.			25a. DATE REC'D. BY REGISTRAR JAN 17 1984			

BP. _____



Handwritten text, possibly a list or notes, located in the middle section of the page.

Handwritten text at the bottom left, including a date "10/10" and a signature.

Handwritten text at the bottom right, possibly a signature or a note.

Handwritten text at the very bottom of the page, possibly a footer or a final note.

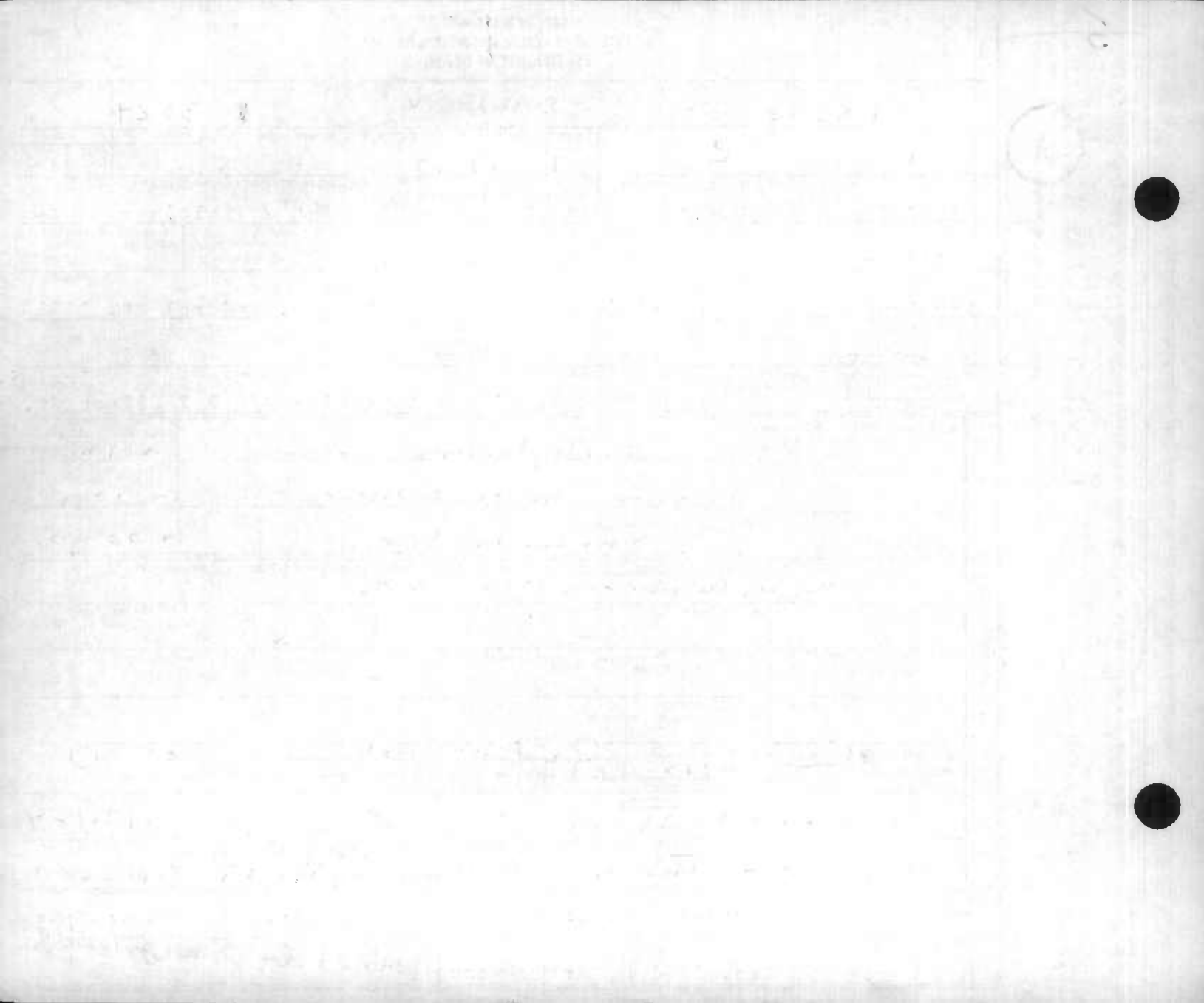
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/B1
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) IRENE M. DAWSON						2a. DATE OF DEATH MONTH 1 DAY 30 YEAR 84			2b. HOUR M		
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH 1 DAY 14 YEAR 17		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		7. UNDER 1 YEAR MONTHS DAYS 		7b. UNDER 24 HRS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY Baltimore MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2900 East Federal Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2900 E. Federal St. 21213			
14. FATHER'S NAME FIRST Arthur MIDDLE Mayo LAST Mayo				15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Woodson LAST Woodson				ADDRESS Danville, Virginia			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. 230-30-5054		17. INFORMANT Fisher & Watkins F/H 707 Wilson St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 3989 IMMEDIATE CAUSE (a) Arrhythmia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~ 1 hr.	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Rheumatic Heart Disease.										~ 30 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c) Rheumatic Fever.										~ 50 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension. H/O CVA											
19a. DATE OF OPERATION NO		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NO				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) NO							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA		21f. LOCATION STREET NA CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from 1983 Feb 19 1981 to 1 19 83 , that (I) (we) lost saw the deceased alive on 10/25 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Mahmud A. Thamer MD.				DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/31/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mahmud A. Thamer.				22e. ADDRESS Cardiology Division Baltimore City Hospitals. Baltimore, MD							
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 2/4/84		23c. NAME OF CEMETERY OR CREMATORY Oakhill Cemetery		23d. LOCATION CITY OR TOWN Danville, COUNTY Virginia STATE VA					
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc, 1101 E North Avenue ADDRESS Danville, Virginia				25a. DATE REC'D BY REGISTRY JAN 31 1984 25b. REGISTRAR'S SIGNATURE [Signature]							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

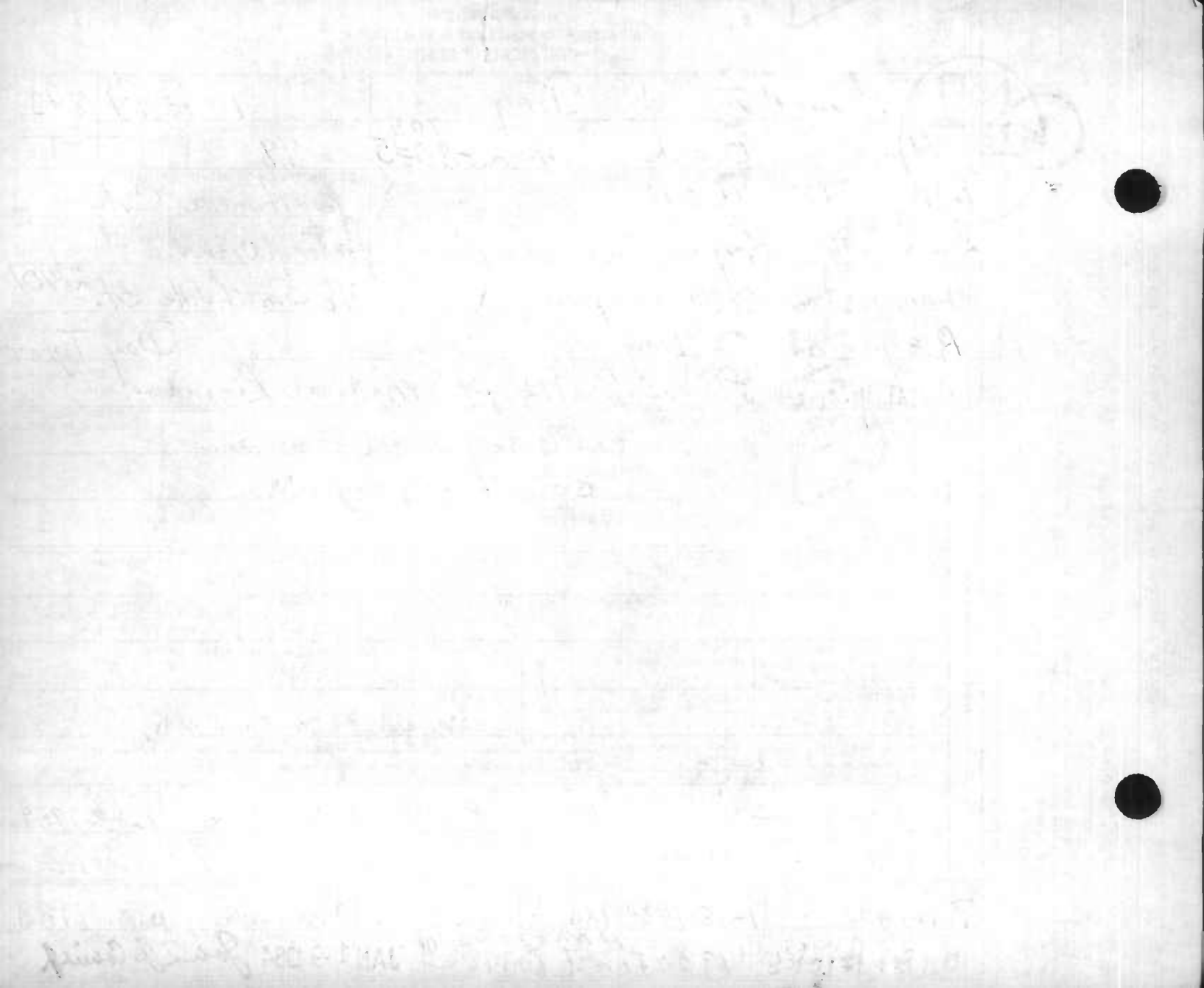
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Saunders W Day				2a. DATE OF DEATH MONTH 1 DAY 13 YEAR 84		2b. HOUR 842 M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH 4 DAY 23 YEAR 1905		6. AGE (IN YEARS (LAST BIRTHDAY)) 78 YRS.	
7a. BIRTHPLACE (CITY AND STATE) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Balto. City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Key Circle Hospice		12. USUAL OCCUPATION (GIVE OCCUPATION FOR MOST OF WORKING LIFE) factory worker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME (TYPE OR PRINT) Raymond Day		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) Carrie Day Tylor		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) WWI Yes WWII			
17. SOCIAL SECURITY NO. 125-16-5792		17. INFORMANT ADDRESS pts medical Record -					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) respiratory arrest - c septicemia DUE TO, OR AS A CONSEQUENCE OF (b) Cold / poly myositis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1-9-1984 to 1-13-1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Caroline Attended by Dr. COOK DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 1-13-1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. C. SHAH				22e. ADDRESS Key Circle Hospice - BALTIMORE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-18-1984		23c. NAME OF CEMETERY OR CREMATORY md Veterans cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, P.A. md	
24. FUNERAL DIRECTOR NAME die. Hicks III ADDRESS 1922 Forest Drive				25. DATE REC'D. BY REGISTRAR JAN 19 1984 REGISTRAR'S SIGNATURE John J. Grier			

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 8 9 5

1. FOR
STATE
REGISTRAR

REG. NO.

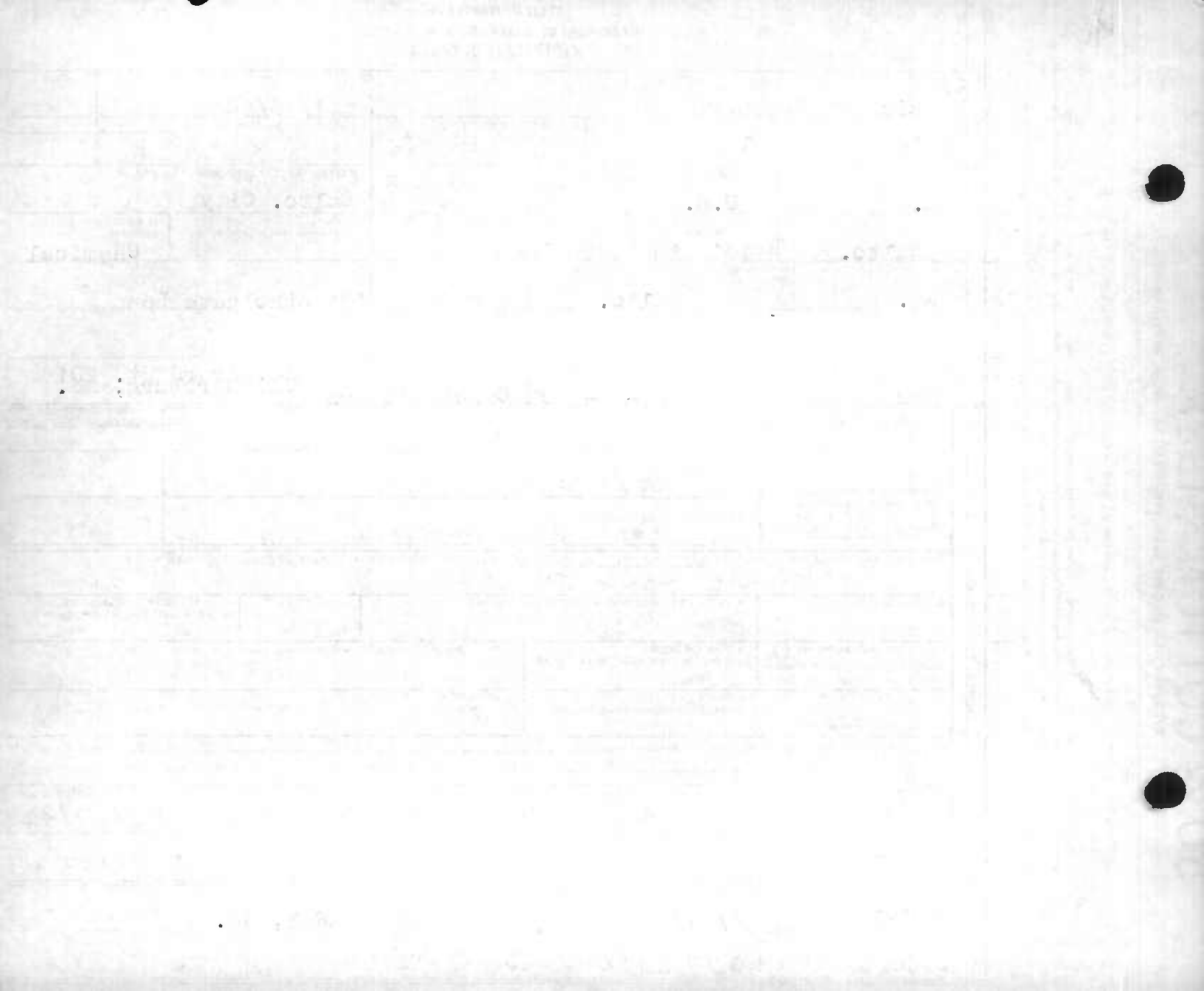
1. DECEASED NAME (TYPE OR PRINT) Richard DeBerry			2a. DATE OF DEATH MONTH DAY YEAR 1/16/84		2b. HOUR M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 4 15 25		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ga.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 101 Atholgate Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY Chemical
13a. STATE MD.		13b. COUNTY Balto.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 254-20-3092		17. INFORMANT Carol Adkison ADDRESS 416 Girard St. 201 Gaithersburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SUDDEN DEATH - UNKNOWN CAUSE 5850 DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE MI. DUE TO, OR AS A CONSEQUENCE OF (c) PROBABLE HYPERKALEMIA CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CHRONIC RENAL FAILURE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE MD		22c. DATE SIGNED 1/17/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUDHI CHINIRISNA, M.D.		22e. ADDRESS 803 N. EUTAW ST. BALTO, MD. 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/21/84		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE Adel, Ga.					
24. FUNERAL DIRECTOR NAME C. Wainwright		ADDRESS 2700 Edmondson		25a. DATE REC'D. BY REGISTRAR JAN 18 1984	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) bovey Jr DeCator			2a. DATE OF DEATH MONTH DAY YEAR January 16, 1984			2b. HOUR 13 ⁰⁰ AM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 24 1916		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Northumberland Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEATON MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY Pvt. Family	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1928 Druid Hill Ave. Baltimore, Maryland 21217	
14. FATHER'S NAME FIRST MIDDLE LAST Jessie Day				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Corbin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 226-16-3827D		17. INFORMANT ADDRESS Nadine Morse Baltimore, Maryland 21216			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MM 40/174 WEEKS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>SEPTICEMIA ; HEAVY STROKE WITH EMBOLISM ; DECUBITI</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 16</u> , 19 <u>83</u> , to <u>JAN 16</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>JAN. 15</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Charles Rosenfarb, MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES ROSENFARB, MD						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/19/1984		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		
24. FUNERAL DIRECTOR NAME Nutter & Sons 2501 Gwynns Falls Pkwy. Funeral Home Inc. Baltimore, Maryland 21216						24a. DATE REG'D. BY REGISTRAR JAN 17 1984		24b. REGISTRAR'S SIGNATURE John J. Conner	

1. This certificate must be filed within 72 hours after death.

2. This certificate must be filed within 72 hours after death.

3. This certificate must be filed within 72 hours after death.

4. This certificate must be filed within 72 hours after death.

5. This certificate must be filed within 72 hours after death.

6. This certificate must be filed within 72 hours after death.

7. This certificate must be filed within 72 hours after death.

8. This certificate must be filed within 72 hours after death.

9. This certificate must be filed within 72 hours after death.

10. This certificate must be filed within 72 hours after death.

11. This certificate must be filed within 72 hours after death.

12. This certificate must be filed within 72 hours after death.

13. This certificate must be filed within 72 hours after death.

14. This certificate must be filed within 72 hours after death.

15. This certificate must be filed within 72 hours after death.

Female	Black	24	1916	Baltimore City
Co.	U. S. A.	X		
Baltimore				Domestic
Maryland	Baltimore	X		1928 Davis Hill Ave.
Jessie	Boy			Baltimore, Maryland 21217
No	225-16-3810 Machine Horse			Baltimore, Maryland 21216
				2803 N. Wilson St.
				Cornish

General Home Inc. Baltimore, Maryland 21216
 Mother & Sons 2801 Gwynn Falls Pkwy.
 1/19/1984 Arthur Memorial Park
 Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

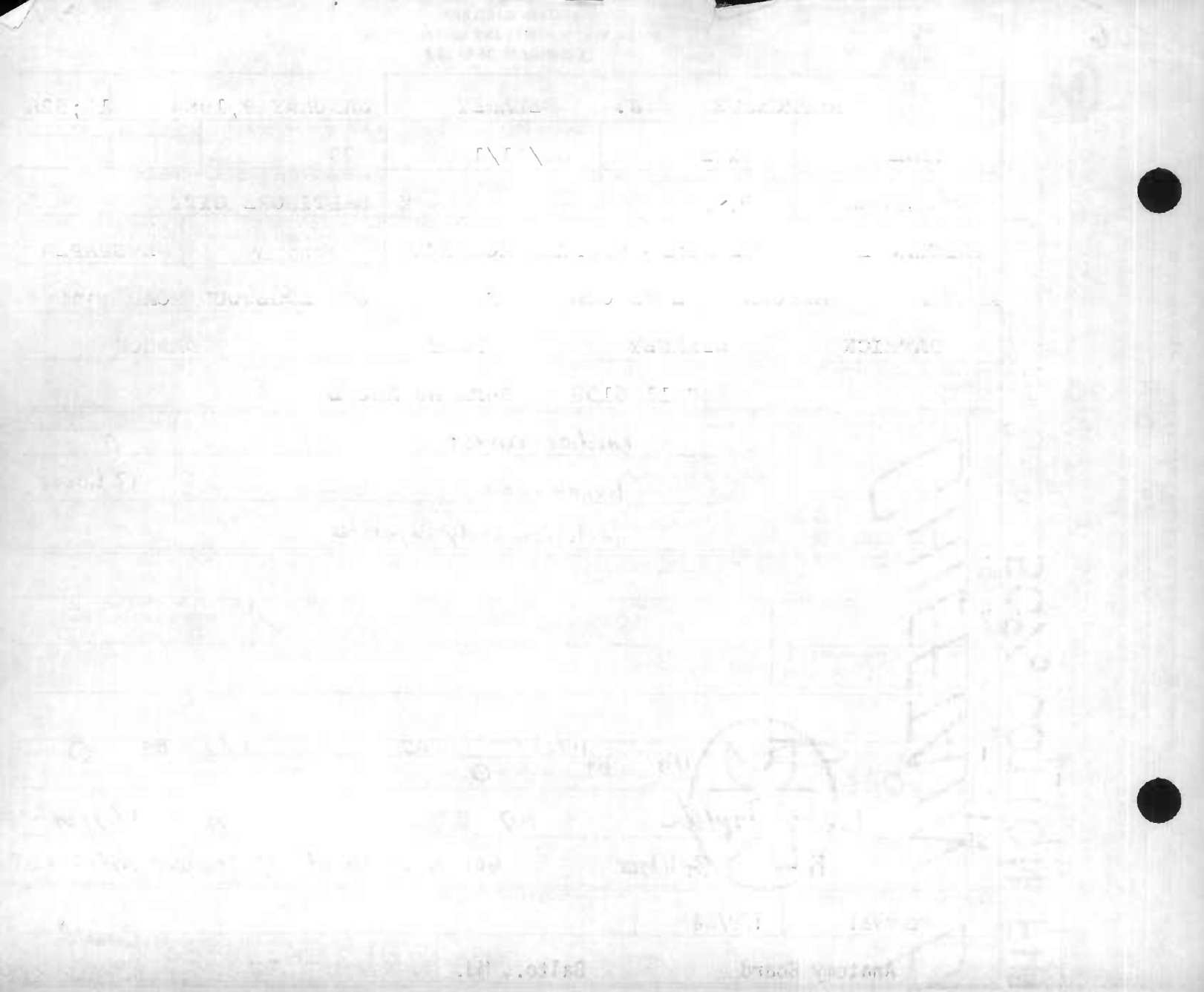
IMPORTANT: If item 21 is marked as item 18 being any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALPHONSUS J. DELANEY			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 9, 1984		2b. HOUR 10:52A
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 08/31/1904		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Newfoundland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY NEWSPAPER
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY HARFORD	13c. CITY OR TOWN EDGEWOOD	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST PATRICK DELANEY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY DAWSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 091106108		17. INFORMANT ADDRESS SAME AS ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 7291 IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) hypotension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) inclusion body myositis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 12 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/25/1982 to 1/9/84 , that (I) (we) last saw the deceased alive on 1/9/84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Petr C. Belitsa		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/9/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Petr C. Belitsa		22e. ADDRESS 601 N. Wolfe St. Baltimore Md. 21205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE 1/9/84	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JAN 12 1984	25b. REGISTRAR'S SIGNATURE [Signature]



BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ZELENE (ZELEN)						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> 1-14-84		2b. HOUR M			
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH 5 DAY 27 YEAR 94	6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN 	2c. DATE PRONOUNCED DEAD 1-14-84		2d. HOUR 1:36P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 809 E. 41st Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 809 East 41st Street 21218			
14. FATHER'S NAME FIRST James MIDDLE LAST Grant		15. MOTHER'S MAIDEN NAME FIRST Victorine MIDDLE LAST Jefferson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 251-32-9402		17. INFORMANT Zelene Hudnell ADDRESS 809 East 41st Street							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margarita A. Koroll		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 1-15-84			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Koroll, M.D.		ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/19/84		23c. NAME OF CEMETERY OR CREMATORY Mount Zion Cemetery		23d. LOCATION CITY OR TOWN Baltimore COUNTY Co. STATE Md.					
24. FUNERAL DIRECTOR NAME William C March F/H Inc. ADDRESS 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR JAN 19 1984		25b. REGISTRAR'S SIGNATURE John J. Carver					



RECEIVED
JUN 1 1968

1968 JUN 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph A. DeLuca					2a. DATE OF DEATH MONTH DAY YEAR January 4, 1984			2b. HOUR 5 A M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 7, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1526 Lakeside Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) drapery install.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1526 Lakeside Avenue, 21218	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph DeLuca				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosina DeLuca					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 216-16-3924		17. INFORMANT ADDRESS Mrs. Marie DeLuca, 1526 Lakeside Ave. 21218			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5355 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) GASTRITIS AND VOMITING									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ASCD - HYPERTENSION									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —					
22a. I certify that (I) (this hospital) attended the deceased from 1-4-83 , 19 83 , to 1-3- , 19 84 , that (I) (we) lost saw the deceased alive on 1-3- , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE G. R. Rao				DEGREE —				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. R. Rao				22e. ADDRESS 3128 HARFORD ROAD, BALTIMORE, MD 21218					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 7, 1984		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Com.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.			
24. FUNERAL DIRECTOR NAME Joseph N. Zannino, 263 S. Conkling St.				25a. DATE REC'D. BY REGISTRAR JAN 6 1984		25b. REGISTRAR'S SIGNATURE John J. Canard			

BP

CHINA MARK 1701010

Handwritten notes and a faint circular stamp are visible on the lined paper. The text is mostly illegible due to fading and bleed-through from the reverse side of the page. Some faint words like "CHINA" and "MARK" are visible in the stamp area.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 0 0

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Charles Frederick Dempsey		2a. DATE OF DEATH MONTH DAY YEAR 1 6 84	
3 SEX Male		2b. HOUR 1231 A	
4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Feb. 6 1914	
6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7b. HOUR 1231 A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Meade, Florida		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident 1450 sp	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Beth. Stell		12b. KIND OF BUSINESS OR INDUSTRY B & O Railroad	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore	
13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS Baltimore, Maryland 1050 Eden Street 21205		14. FATHER'S NAME FIRST MIDDLE LAST George Dempsey	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgia		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	
16b. SOCIAL SECURITY NO. WW II		17. INFORMANT ADDRESS 21234 Apt. H	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1991 CARDIAC ARREST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Undifferentiated Carcinoma (c) Primary Unknown R/O PROSTATE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
21g. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
22a. I certify that (I) (this hospital) attended the deceased from 84 Nov 30 19 83 to Jan 6 19 84, that (I) (we) lost saw the deceased alive on Jan 6 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE J. Taylor		22c. DATE SIGNED 1/6/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jimmy Taylor		22e. ADDRESS 2600 LIBERTY HTS, AVE	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 10, 1984	
23c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR Nutter and Sons Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR JAN 9 1984	
25b. REGISTRAR'S SIGNATURE John J. Carver		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1940
1941
1942
1943
1944
1945
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
2036
2037
2038
2039
2040
2041
2042
2043
2044
2045
2046
2047
2048
2049
2050
2051
2052
2053
2054
2055
2056
2057
2058
2059
2060
2061
2062
2063
2064
2065
2066
2067
2068
2069
2070
2071
2072
2073
2074
2075
2076
2077
2078
2079
2080
2081
2082
2083
2084
2085
2086
2087
2088
2089
2090
2091
2092
2093
2094
2095
2096
2097
2098
2099
2100

1940
1941
1942
1943
1944
1945
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
2036
2037
2038
2039
2040
2041
2042
2043
2044
2045
2046
2047
2048
2049
2050
2051
2052
2053
2054
2055
2056
2057
2058
2059
2060
2061
2062
2063
2064
2065
2066
2067
2068
2069
2070
2071
2072
2073
2074
2075
2076
2077
2078
2079
2080
2081
2082
2083
2084
2085
2086
2087
2088
2089
2090
2091
2092
2093
2094
2095
2096
2097
2098
2099
2100

1940
1941
1942
1943
1944
1945
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
2036
2037
2038
2039
2040
2041
2042
2043
2044
2045
2046
2047
2048
2049
2050
2051
2052
2053
2054
2055
2056
2057
2058
2059
2060
2061
2062
2063
2064
2065
2066
2067
2068
2069
2070
2071
2072
2073
2074
2075
2076
2077
2078
2079
2080
2081
2082
2083
2084
2085
2086
2087
2088
2089
2090
2091
2092
2093
2094
2095
2096
2097
2098
2099
2100

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove coffin papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8400901 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST JAMES MIDDLE S. LAST DENNIS, JR. (BABY BOY) (BAKER)			2a. DATE OF DEATH MONTH DAY YEAR 1-22-84		7b. HOUR 4:15 AM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11-12-83		6. AGE (IN YEARS LAST BIRTHDAY) — YRS. 210 MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY NA				
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST James MIDDLE S. LAST DENNIS		15. MOTHER'S MAIDEN NAME FIRST Yvonne MIDDLE J. LAST Baker				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Yvonne Baker 1102 N. Stricker Street		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary failure 4249 DUE TO, OR AS A CONSEQUENCE OF (b) Endocarditis DUE TO, OR AS A CONSEQUENCE OF (c) Prematurity Error						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour Weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a PREMATURITY						
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11-12, 1983, to 1-22, 1984, that (I) (we) lost saw the deceased alive on 1-22, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE JUDITH L. CHIPCHIN		DEGREE (no)		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-22-84
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/26/84		23c. NAME OF CEMETERY OR CREMATORY Eastview Mem.Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc, 1101 E North Avenue				25a. DATE RECD BY REGISTRAR JAN 25 1984		
25b. REGISTRAR'S SIGNATURE John L. Carney						

1056

1056

20%

1056

1056

1056

1056

1056

1056

[Faint, illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 0 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LOUISE			FIRST MIDDLE LAST DEPSE			2a. DATE OF DEATH MONTH DAY YEAR 1-8-84			2b. HOUR 3:15 AM		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR 9 6 1895			6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY ---		
13a. STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Arbutus			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John G. Hertlein			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margarethe Buchsbaum			13e. STREET ADDRESS / ZIP CODE 90 Oaklee Village 21229					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 213-48-4252			17. INFORMANT Gordeon C. Cooper			ADDRESS 312 Harlem Lane 21228		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Coronary heart failure DUE TO, OR AS A CONSEQUENCE OF: (b) atherosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (c) Sigmoid Volvulus										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Sigmoid Volvulus											
19a. DATE OF OPERATION 11/8/83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Sigmoid Volvulus			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/21 , 19 83 , to 1/8 , 19 84 , that (I) (we) lost saw the deceased alive on 1/8 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]						DEGREE M.D.			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert McFadden						22e. ADDRESS St. Agnes Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/11/84			23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.						25a. DATE REC'D. BY REGISTRAR JAN 9 1984			25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director retained by the hospital or attending physician.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SECRET



SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 4 0 0 9 0 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERTA O. DESKINS				2a. DATE OF DEATH MONTH DAY YEAR JANUARY 30, 1984		2b. HOUR 6:40a m	
3. SEX female		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 4 2 1936		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		13b. COUNTY Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21216 1710 Dukeland Street	
14. FATHER'S NAME FIRST MIDDLE LAST Edgar Smith		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Black					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-32-3022		17. INFORMANT ADDRESS Courtland Deskins 1710 Dukeland St			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 5715 IMMEDIATE CAUSE (a) <input checked="" type="checkbox"/> GASTROINTESTINAL BLEEDING DUE TO, OR AS A CONSEQUENCE OF (b) ESOPHAGEAL VARICES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PORTAL HYPERTENSION DUE TO ADVANCED CIRRHOSIS OF LIVER APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ACUTE OR CHRONIC LIVER FAILURE; HEPATORENAL SYNDROME; RENAL FAILURE; COAG- ULOPATHY; PNEUMONIA; RIGHT PLEURAL EFFUSION; GASTROINTESTINAL BLEEDING WITH Jan. 21, 1984 GASTROINTESTINAL BLEEDING WITH 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 21b. TIME OF INJURY GASTRIC ULCER OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH HOUR A.M. MONTH DAY YEAR (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19 21d. INJURY OCCURRED 21e. PLACE OF INJURY 21f. LOCATION WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) STREET CITY OR TOWN COUNTY STATE AT WORK AT WORK							
22a. I certify that (I) this hospital attended the deceased from Jan. 12, 19 84, to Jan. 30, 19 84, that (I) we last saw the deceased alive on Jan. 30, 19 84, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death.							
22b. SIGNATURE K. George Thomas, M.D.				DEGREE MD		22c. DATE SIGNED 1/30/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. GEORGE THOMAS, M.D.				22e. ADDRESS CHURCH HOSPITAL 100 N. BROADWAY, BALTO., MD. 21231			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/2/84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Md	
24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Ave				25a. DATE REC'D. BY REGISTRAR JAN 31 1984			

20% COTTON

CHILLYN



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 0 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAMONA B. DETTY			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 10, 1984		2b. HOUR 3:10p M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4-15-1920	6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baltimore City	12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ralph Stafford		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cynthia Stone			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 294-16-5980	17. INFORMANT ADDRESS Ralph E. Detty-405 Kingston Rd. 21229		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE RIGHT CEREBRAL INFARCT</u> <u>4331</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>RIGHT CAROTID ENDARTERECTOMY</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Insulin dependent diabetes mellitus. hypertension</u>					
19a. DATE OF OPERATION <u>1/6/84</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>RIGHT CAROTID ARTERY STENOSIS</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/3/84</u> , 19 <u>84</u> , to <u>1/10</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>1/10</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Christopher S. McCullough</u>		DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>1/10/84</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CHRISTOPHER S. MCCULLOUGH</u>		22e. ADDRESS <u>900 S. Caton Ave. Baltimore, Md. 21229</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>1-14-84</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Friends Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Londonderry Ross Ohio</u>	
24. FUNERAL DIRECTOR <u>Baltimore, Md. 21229</u> <u>HUBBARD FUNERAL HOME, INC. 4107 Wilkens Ave.</u>		25a. DATE REC'D. BY REGISTRAR <u>JAN 12 1984</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Grier</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

12. 3. 1990 11:10 AM

22212 . 12 notes 304

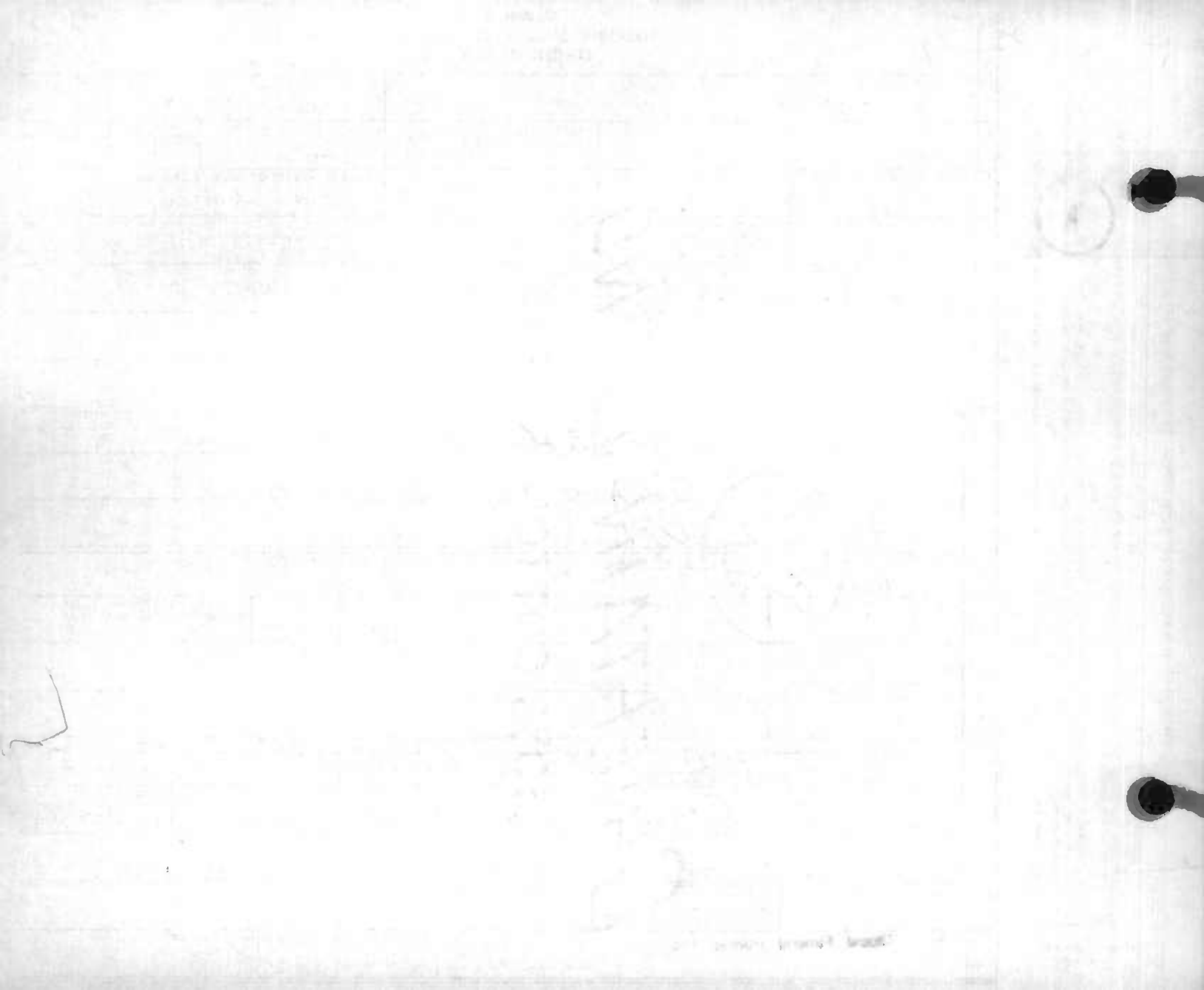
211

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Catherine E. DIPPEL				2a. DATE OF DEATH MONTH DAY YEAR January 17, 1984			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb 8, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 506 S. Highland Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. STATE Maryland				13b. COUNTY -----		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST John Burns				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lenora Seton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-36-5845		17. INFORMANT ADDRESS 21224 Katherine Hessler 506 S. Highland Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4920 IMMEDIATE CAUSE (a) <i>Arterio-Sclerotic Cardio-Vascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Emphysema</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Alcoholism Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Mild C.V.D.</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1/31</i> , 19 <i>82</i> , to <i>1/17</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>7/27</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Joseph R. Liberto</i>				DEGREE <i>MD</i>		22c. DATE SIGNED Jan 18, 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph R. Liberto, MD.				22e. ADDRESS 3508 Bank Street Baltimore Md. 21224			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 20, 84		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem Baltimore, Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <i>Dippel Funeral Homes, Inc.</i> ADDRESS 7110 Belair Road Baltimore, Md.				25a. DATE REC'D. BY REGISTRAR JAN 19 1984		25b. REGISTRAR'S SIGNATURE <i>John J. Givens</i>	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 0 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RICHARD B. DISSINGER			2a. DATE OF DEATH MONTH DAY YEAR 01/ 15/ 84			2b. HOUR 6:30pm		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Nov. 14, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gen. Sales Mgt.		12b. KIND OF BUSINESS OR INDUSTRY KOPPERS Co.		
13a. STATE Maryland			13b. COUNTY BALTIMORE		13c. CITY OR TOWN CARNY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST VERNE T. DISSINGER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LEONA BARE			13e. STREET ADDRESS / ZIP CODE 2314 COVERED BRIDGE GARTH 21234		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.-II 174-203188		17. INFORMANT ADDRESS FAMILY RECORDS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1919 IMMEDIATE CAUSE (a) Brain stem Intarction DUE TO, OR AS A CONSEQUENCE OF (b) Cerebellar Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Intracranial Tumor							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days 6 mos	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.								
19a. DATE OF OPERATION 1/12/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Left Jugular Foramen Tumor Brainstem Compression			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Jan 11 1984 to Jan 15 1984, that (I) (we) last saw the deceased alive on Jan 15 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Alvin Coughlin, M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/15/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) COGHILL		22e. ADDRESS Johns Hopkins Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 18 1984		23c. NAME OF CEMETERY OR CREMATORY CHESAUNT GROVE		23d. LOCATION CITY OR TOWN COUNTY STATE MARYSVILLE PERRY Penn.		
24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIES HARFORD ROAD		ADDRESS 8800		25a. DATE REC'D. BY REGISTRAR JAN 17 1984		25b. REGISTRAR'S SIGNATURE John J. Conner		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use on the burial transit permit. This permit remains the property of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Philip Joseph DiVenti</i>				2a. DATE OF DEATH MONTH <i>01</i> DAY <i>23</i> YEAR <i>84</i>		2b. HOUR <i>5:30 AM</i>
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>March</i> DAY <i>6</i> YEAR <i>1923</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>60</i> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore, City</i> MD.
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Mercy Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Brick Layer</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Eldersburg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST <i>Joseph</i> MIDDLE <i>DiVenti</i> LAST <i>Petrina</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Petrina</i> MIDDLE <i>Puzza</i> LAST <i>Puzza</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		
16b. SOCIAL SECURITY NO. <i>WW 11</i>		17. INFORMANT <i>Mrs Helen M DiVenti</i>		18. ADDRESS <i>Same As 13e</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>1629 metastatic lung CA</i> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>staph & streptococcus pneumonia</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Marie Amos Dobyns MD</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/23/84</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARIE AMOS DOBYNS</i>		22e. ADDRESS <i>301 St. Paul Place Balt, Md</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1/26/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gardens Of Faith</i>		23d. LOCATION CITY OR TOWN <i>Baltimore, Maryland</i> COUNTY STATE
24. FUNERAL DIRECTOR NAME <i>Leonard J Ruck Inc. Baltimore, Maryland</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 24 1984</i>		25b. REGISTRAR'S SIGNATURE <i>P. J. G. G. G.</i>

THE NATIONAL ARCHIVES
COLLECTIONS DIVISION
1000 18th Street, NW
Washington, DC 20036



NO
C
B
%

NO
C
B
%



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 0 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Jeannette May Dixon</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>January 16, 1984</i>		2b. HOUR <i>2:30 PM</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 27, 1925</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>58</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>South Baltimore General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Anne Arundel</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Norman Slacum</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Cunningham</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>219-18-1892</i>		17. INFORMANT ADDRESS <i>Robert EL Dixon Same as #13</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardio Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>10 yrs</i>
---	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>1-14-84</i> 19 <i>84</i> to <i>1-16-84</i> 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>1-14-84</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Benjamin Bendann</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>1-19-84</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Benjamin Bendann, M.D.</i>		22e. ADDRESS <i>1606 Hammonds Lane MFD. (TR.), Baltimore, Md. 21225</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>1/20/1984</i>	23c. NAME OF CEMETERY OR CREMATORY <i>GLEN HAVEN Mem. Pk.</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie, A. A. Co., Md.</i>
24. FUNERAL DIRECTOR NAME <i>McCully Funeral Homes</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 20 1984</i>	25b. REGISTRAR'S SIGNATURE <i>John J. [Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 0 9

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marjorie E. Dixon			2a. DATE OF DEATH MONTH 1 DAY 8 YEAR 84			2b. HOUR 1:00 pm	
3. SEX F	4. RACE BLACK	5. DATE OF BIRTH MONTH 6 DAY 3 YEAR 12		6. AGE (IN YEARS LAST BIRTHDAY) 72 71 YRS.		IF UNDER 1 YEAR MONTHS 71 DAYS 71 HOURS 71 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? MD.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2319 KoKo Lane 21216		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Robert MIDDLE Jason LAST Young		15. MOTHER'S MAIDEN NAME FIRST Bertha MIDDLE Young LAST Young		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
16b. SOCIAL SECURITY NO.		17. INFORMANT James Dixon		ADDRESS 2319 KoKo Lane 21216			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) adenocarcinoma of lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 1 week 1 year
---	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): ectopic ACTH hypokalemia from adenocarcinoma of lung			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1980 , 19 84 , to 1/8 , 19 84 , that (I) (we) last saw the deceased alive on 12/5 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Richard A. Berg		22c. DATE SIGNED 1/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard A. Berg		22e. ADDRESS Suite 400 711 W 40th St Baltimore, Md 21211	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-14-84	23c. NAME OF CEMETERY OR CREMATORY St. Adolph's	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, MD.
24. FUNERAL DIRECTOR NAME Baileys 4.H. 1348 N. Calhoun St.		25a. DATE REC'D. BY REGISTRAR JAN 17 1984	
25b. REGISTRAR'S SIGNATURE John J. Arnold			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

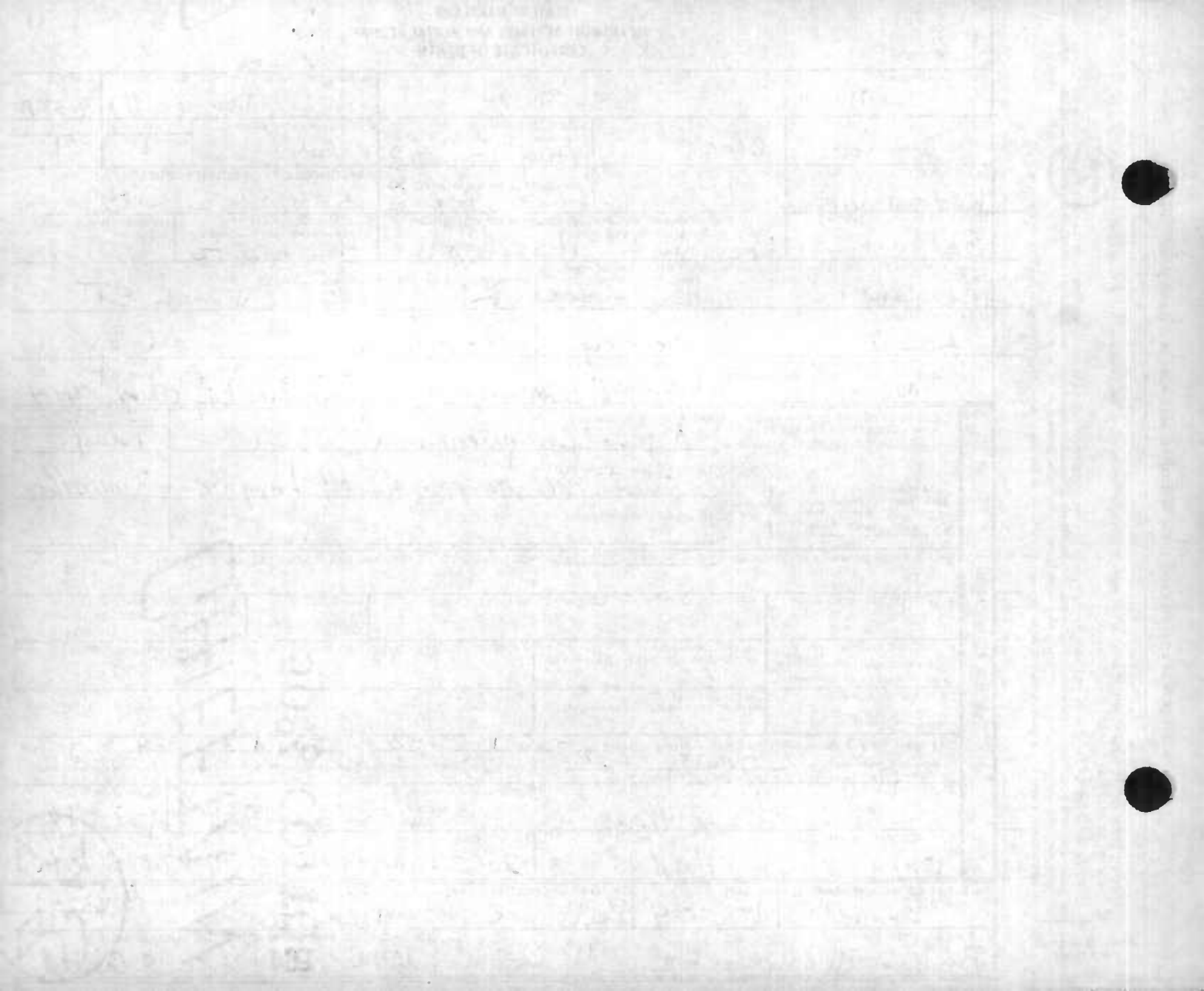
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REG. NO.

MEDICAL CERTIFICATION

BP.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and that it be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) MYRNA Beverly DORKINS						2a. DATE OF DEATH MONTH DAY YEAR 01 06 84				2b. HOUR 6:15A.M.	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 08 31 37		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5506 Cadillac Ave. 21207			
14. FATHER'S NAME FIRST MIDDLE LAST Carroll Elmer Addison				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn B. Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 218-36-0764		17. INFORMANT ADDRESS Vernon R. Dorkins 5506 Cadillac Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE PULMONARY EMBOLISM. 4151 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) BILATERAL. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1-6- 19 84 to 1-6- 19 84 , that (I) (we) last saw the deceased alive on 1-6- 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Anusha Belani				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-6-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANUSHA BELANI				22e. ADDRESS SINAI HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 11, 1984		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.					
24. FUNERAL DIRECTOR Nutter and Sons Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR JAN 9 - 1984		25b. REGISTRAR'S SIGNATURE John J. Lewis					

RECEIVED
FEB 11 1964

ADVISORY

ON THE



RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED



RECEIVED

RECEIVED

RECEIVED

RECEIVED

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 1 2

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANK A DORN			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 3 1984			2b. HOUR 3:30 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 28 1898		6. AGE (IN YEARS (LAST BIRTHDAY)) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Penna. R.R.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Francis X. Dorn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Justina M. Wiedman		13e. STREET ADDRESS 7603 Avondale Avenue 21224			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 717-07-6132		17. INFORMANT ADDRESS Margaret M. Dorn - Same as line 13e.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIOPULMONARY ARREST**4100**

DUE TO, OR AS A CONSEQUENCE OF

(b) **MYOCARDIAL INFARCTION**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

ALZHEIMER'S DISEASE, RT. PARIETAL STROKE

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/24 , 19 83 , to 1/3 , 19 84 , that (I) (we) lost saw the deceased alive on 1/3/84 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Andrew Yang M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW YANG				22e. ADDRESS BALTIMORE CITY HOSPITAL			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/7/84		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue, Dundalk, MD 21222				25a. DATE REC'D. BY REGISTRAR JAN 10 1984		25b. REGISTRAR'S SIGNATURE John J. Conner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



SECRET
NO. 100-100000

1. The first part of the document is a list of names and titles, including the names of the members of the committee and the names of the persons who were interviewed. The names are listed in alphabetical order, and the titles are listed in the order in which they were interviewed.

2. The second part of the document is a list of the questions that were asked of the interviewees. The questions are listed in the order in which they were asked, and the answers are listed in the order in which they were given.

3. The third part of the document is a list of the answers that were given to the questions. The answers are listed in the order in which they were given, and the questions are listed in the order in which they were asked.

4. The fourth part of the document is a list of the conclusions that were drawn from the interviews. The conclusions are listed in the order in which they were drawn, and the questions are listed in the order in which they were asked.

5. The fifth part of the document is a list of the recommendations that were made as a result of the interviews. The recommendations are listed in the order in which they were made, and the questions are listed in the order in which they were asked.

Page 100



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 1 3

1- FOR
STATE
REGISTRAR

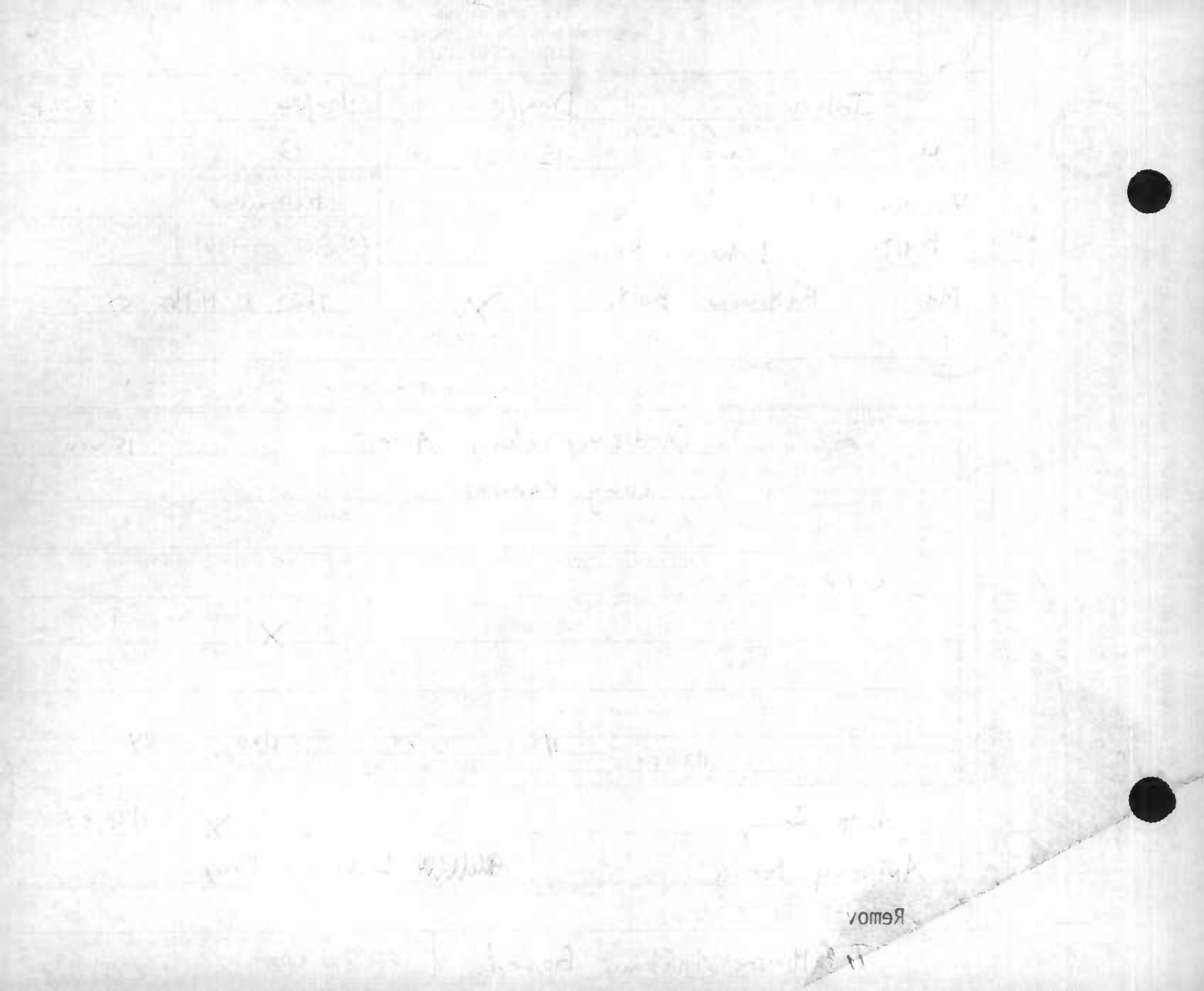
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) John Doyle			2a DATE OF DEATH MONTH DAY YEAR 1/30/84		2b HOUR 8:21 P.M.	
3 SEX M.	4 RACE BLACK	5 DATE OF BIRTH MONTH DAY YEAR 12 25 00		6 AGE (IN YEARS LAST BIRTHDAY) 83		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia, USA	7b CITIZEN OF WHAT COUNTRY? US	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD		
10 CITY OR TOWN OF DEATH Balt.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hosp			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (Soc. Security)		12b KIND OF BUSINESS OR INDUSTRY
13a STATE Md.		13b COUNTY Baltimore	13c CITY OR TOWN Balt.	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 1622 N. N. Hwy St 21216	
14 FATHER'S NAME FIRST MIDDLE LAST David Doyle		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Green				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 231-26-8132		17. INFORMANT ADDRESS Ms. Karlita Johnson (Same as #13.)		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) COPD						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1/30/84 , 19 84 , to 1/30 , 19 84 , that (I) (we) last saw the deceased alive on 1/30/84 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Anthony Foong		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/30/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anthony Foong		22e. ADDRESS Lutheran Hosp.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 1/31/84		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
24 FUNERAL DIRECTOR NAME To Baltimore Anthony Board.		ADDRESS FFB 2		25a. DATE REC'D. BY REGISTRAR 1984		25b. REGISTRAR'S SIGNATURE James E. Carried

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4-571

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.



4-18

Total 1.00

1.00

1.00

1.00

1.00

1.00

X

1.00

X

1.00

Remov

1.00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, how any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 914	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Benjamin F. Drager</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>Jan. 14, 1984</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>April 23, 1916</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>67</i> YRS.		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1711 Patapsco St. Balto. Md. 21230</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret. F. Z. McHenry</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Lumber & Saw</i>				
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Theodore Drager</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Kent</i>		13d. STREET ADDRESS / ZIP CODE <i>1711 Patapsco St. Balto. Md. 21230</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215-01-7154</i>		17. INFORMANT ADDRESS <i>Mrs. Lavina M. Drager, Same as above</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Widespread metastatic disease.</i> 1029 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Squamous cell carcinoma of the Lung.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>4 mos.</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <i>Emphysema</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 13, 1984</i> to <i>Jan 14, 1984</i> , that (I) (we) last saw the deceased alive on <i>Jan 13, 1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>George Talber</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>Jan 16, 1984</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>GEORGE TALBER, M.D.</i>		22e. ADDRESS <i>600 Light St. Balt. Md. 21230</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Jan. 18, 1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		
24. FUNERAL DIRECTOR <i>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>		23e. DATE REC'D. BY REGISTRAR <i>JAN 17 1984</i>		
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>				

BP

1000

1000

1000

1000

1000

1000

1000

1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST PENNIE MIDDLE (PENJIE) LAST C. DRAKES										2a. DATE KNOWN OF DEATH <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> 1-12-84	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH 5 DAY 1 YEAR 14		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS 69 YEARS		7. IF UNDER 1 YR. MONTHS DAYS 		7b. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1413 E. Lanvale Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland										13b. COUNTY Baltimore	
14. FATHER'S NAME FIRST James MIDDLE M. LAST Finley										15. MOTHER'S MAIDEN NAME FIRST Burellar MIDDLE LAST Hughley	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 106-20-2775				17. INFORMANT ADDRESS Doris Johnson 2231 Reistertown Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margaret De Snell						TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 1-14-84		
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.						ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/20/84		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery			23d. LOCATION CITY OR TOWN Baltimore, COUNTY STATE Md.		
24. FUNERAL DIRECTOR NAME William C March F/H Inc. ADDRESS 1101 E North Avenue						25a. DATE REC'D BY REGISTRAR JAN 19 1984			25b. REGISTRAR'S SIGNATURE John J. Casper		

RECEIVED
HAWAIIAN ISLANDS
MAY 20 1964

5/20

ARMY 1000
HAWAIIAN ISLANDS

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8400916

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John A. Drexler			2a. DATE OF DEATH MONTH DAY YEAR 01 21 84		2b. HOUR 4:40 AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 05 15		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.		
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY iptician	
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John J. Drexler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ebauer		13e. STREET ADDRESS 205 S. Highland Ave. 21224				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no.		16b. SOCIAL SECURITY NO. 215-01-0388		17. INFORMANT ADDRESS Mrs. J. Drexler, 205 S. Highland Ave. 21224				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4148 CARDIAL ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ISCHEMIC HEART DISEASE, OLD INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) DIABETES MELLITUS								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 1984 to JAN 1984 , that (1) (we) last saw the deceased alive on 1-21-1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.								
22b. SIGNATURE Aidan E. Walsh		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/23/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AIDAN E. WALSH		22e. ADDRESS M.D. 333 ST. PAUL 21202.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/24/84		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus Balto., Md.		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Zannino Funeral Home, 263 S. Conkling St.		ADDRESS		25a. DATE REC'D. BY REGISTRAR JAN 25 1984		25b. REGISTRAR'S SIGNATURE John J. Conkling		

MEDICAL CERTIFICATION

BP

TO HOSPITAL, LIAISON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial transit permit. These pages should be removed from the certificate and retained by the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Unpublished

①

•

• 1997

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 1 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN E. DUDICK			2a. DATE OF DEATH MONTH DAY YEAR January 24 1984		2b. HOUR 10:55A
1. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6-12-1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTIMORE MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COVARD		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE 13a. STATE PA	13b. COUNTY Chesster	13c. CITY OR TOWN Oxford	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS, ZIP CODE 62 S. 3rd St. 19363	
14. FATHER'S NAME FIRST MIDDLE LAST LINK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LINK			

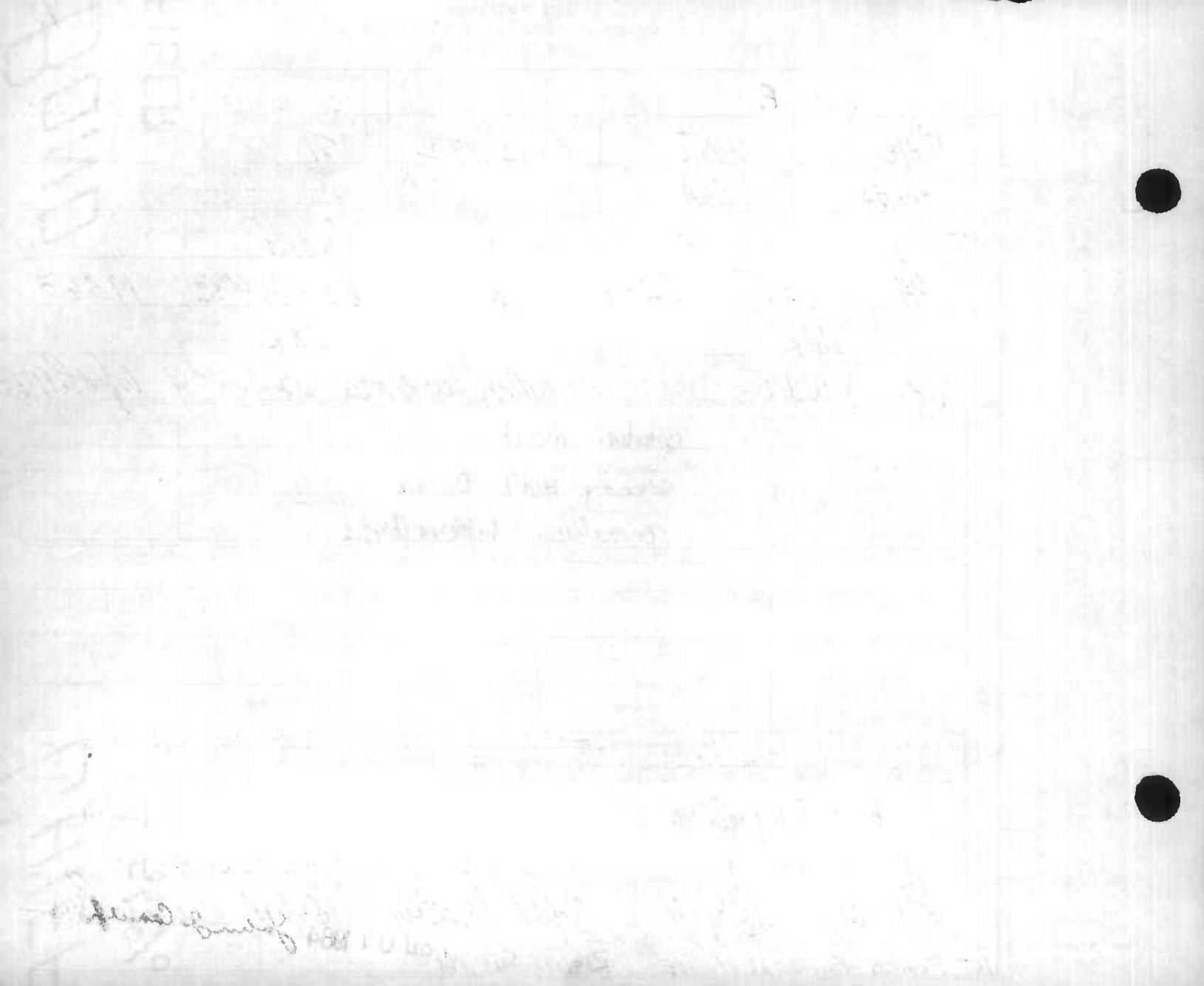
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OF DATES) 190 16 9537	17. INFORMANT ADDRESS MARY LOU PARKER 62 S. 3rd St Oxford Pa 19363
--	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4149 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) generalized arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Injury 18 19 84 to January 24 19 84 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 24 19 84 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
22b. SIGNATURE B. Nguyen MD		DEGREE		22c. DATE SIGNED 1/26/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. NGUYEN MD		22e. ADDRESS 3900 Loch Raven Blvd. Balto Md 21218			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/28/84	23c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery	23d. LOCATION CITY COUNTY STATE Oxford Chesster PA
24. FUNERAL DIRECTOR NAME R.T. FORD FUNERAL HOME		25a. DATE RECEIVED BY FUNERAL DIRECTOR 1/26/84	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THOMAS FRANKLIN DUGGER				2b. HOUR 33 ⁴ AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 04 09 41		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) U. of Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESPERSON		12b. KIND OF BUSINESS OR INDUSTRY PLATE CO.	
13a. STATE MARYLAND				13b. COUNTY ---			
13c. CITY OR TOWN BALTIMORE				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Dugger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Stull			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1958-1964		17. INFORMANT ADDRESS DONNA DUGGER 205 S. WOODYEAR STREET, 21223			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac pulmonary arrest</u> 5860 DUE TO, OR AS A CONSEQUENCE OF (b) <u>end stage renal failure + sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>paraplegia secondary to gunshot wound.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/28</u> , 19 <u>84</u> , to <u>1/29</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>1/28</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u> DEGREE MD				22c. DATE SIGNED 1/29/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JASKULSKY</u>				22e. ADDRESS <u>U. of Md Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 02-01-84		23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE A.A. MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.				25a. DATE REC'D. BY REGISTRAR FEB 1 1984			
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP

271

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 1 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HELEN R. DUKES			2a. DATE OF DEATH MONTH DAY YEAR 01 11 '84		2b. HOUR 8 ³⁵ PM
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 10 24 19		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore City	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Henry Johnston			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Johnston		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 140-12-2225		17. INFORMANT ADDRESS Roosevelt Dukes 3617 W. Saratoga Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1830 Metastatic OVARIAN CANCER DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Walter Zalcman		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER ZALCMAN		22e. ADDRESS SINAI HOSPITAL, BALTO., Md. 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1/17/84	23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Veteran		23d. LOCATION CITY OR TOWN COUNTY STATE Owing Mills, Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 East North Avenue		25a. DATE REC'D. BY REGISTRAR JAN 17 1984			
		25b. REGISTRAR'S SIGNATURE John J. Carney			

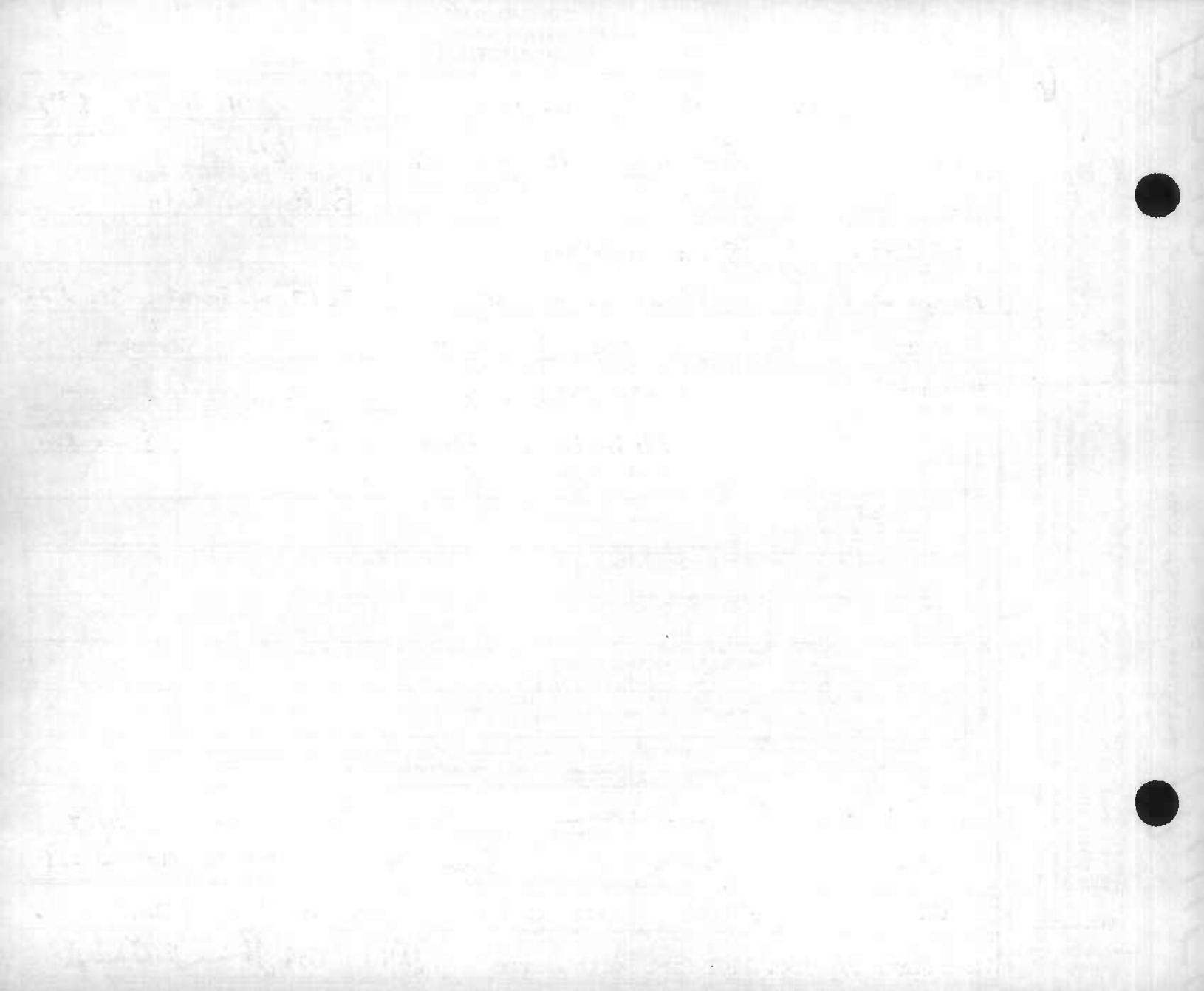
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 2 0

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Rebecca A Dulin			2a. DATE OF DEATH MONTH 1 DAY 16 YEAR 84			2b. HOUR 6:55 AM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH 9 DAY 24 YEAR 07		6. AGE (IN YEARS LAST BIRTHDAY) 76	
7a. BIRTHPLACE (COUNTRY) Selma, Ala.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City	
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. City Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE Md.		13b. COUNTY BALTO		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME (FIRST) UNK. (MIDDLE) (LAST)		15. MOTHER'S MAIDEN NAME (FIRST) ANNIE (MIDDLE) LOU (LAST) Jackson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
17. INFORMANT Clarence L. Jackson		ADDRESS 945 S. Avondale Rd.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

1539 IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

immediate

3 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 7/1/84 , 19____, to 1/16/84 , 19____, that (1) (we) last saw the deceased alive on 1/13/84 , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.							
22b. SIGNATURE Walter Effinger (TYPE OR PRINT)				DEGREE MD		22c. DATE SIGNED 1/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter Effinger				22e. ADDRESS Baltimore City Hospital			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-19-84		23c. NAME OF CEMETERY OR CREMATORY King Mem PK.		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Md.	
24. FUNERAL DIRECTOR NAME AS. A. MORTON & SONS - 1701 LAURENS				25a. DATE REC'D. BY REGISTRAR JAN 17 1984		25b. REGISTRAR'S SIGNATURE Joan J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on page 3, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. NAME JOHN F. SMITH
2. DATE 10-1-68
3. TIME 10:00 AM
4. LOCATION Room 101
5. REASON See below

6. REMARKS See below

7. INITIALS JFS
8. SIGNATURE John F. Smith
9. DATE 10-1-68
10. TIME 10:00 AM

11. REMARKS See below

12. INITIALS JFS

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 2 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HELEN E. DUNCAN			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 21, 1984		2b. HOUR 12:55
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1 31 17		6. AGE (IN YEARS LAST BIRTHDAY) 66	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dietician		12b. KIND OF BUSINESS OR INDUSTRY Hospital
13a. STATE Md.		13b. CITY OR TOWN Darlington	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 373-22-6662		17. INFORMANT ADDRESS Mr. Dosca Duncan (Same as #13.)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 1991 DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Staph epidermidis Septic Shock DUE TO, OR AS A CONSEQUENCE OF, (c) Metastatic adenocarcinoma to spine					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes 1 week 5 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Disseminated Intravascular Coagulation, GI Bleeding					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/21 , 19 84 , to 1/20 , 19 84 , that (I) (we) lost saw the deceased alive on 1/21 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE K. M. Carbone		DEGREE MD		22c. DATE SIGNED 1-21-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. M. Carbone MD		22e. ADDRESS 600 N. WOLFE ST. 21205 MD. Johns Hopkins Hospital, Baltimore			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 1/21/84		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR JAN 26 1984			
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		REGISTRAR'S SIGNATURE John J. Carver	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed without delay after death. It may be a
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove the copy of the permit. Pages 1 and 2 should be kept for 72 hours after death
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1000



30-61-105 5

WICH

ASTORIAL

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 2 2

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
FIRST MIDDLE LAST		F 16 84		2:31 A	
SAMUEL MARTIN DUNN					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M MALE	W WHITE	MONTH DAY YEAR	XXX 81 YRS.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	9. BALTIMORE CITY OR COUNTY OF DEATH			
RUSSIA	U.S.	city			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore	Smal Hoop	MERCHAND		RETAIL	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md	BALTO	BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	6615 Eberle Dr APT. 212 #21215	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
AARON DUNN		BESSIE DUBOIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
NO		215 14 0114		MRS. EDITH DUNN APT. 212	
				6615 EBERLE DR. BALTO., MD 21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>myocardial infarction</u>					
4414					
DUE TO, OR AS A CONSEQUENCE OF					
(b) <u>atherosclerosis</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) <u>renal failure respiratory failure</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
renal failure respiratory failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
1/12/84		abdominal cramps		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR (A.M.) MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
		12:15 P.M. 1 16 1984			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/19</u> , 19 <u>84</u> , to <u>1/16</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>1/16</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Alan Weiss, MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		1/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
ALAN WEISS		Smal Hoop			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
BURIAL		JAN. 17, 1984	BNAI ISRAEL		BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
SOL LEVINSON & BROS., INC.		JAN 23 1984		John J. Carver	
6010 REISTERSTOWN RD. BALTO., MD 21215					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18, then any injury, or other traumatic event, the medical examiner must be notified.

BP

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

FROM THE DIRECTOR, BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

SUBJECT: [Illegible]

[Illegible text block]

[Illegible text block]

[Illegible text block]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 2 3

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Donald L. DURDEN			2a. DATE OF DEATH MONTH DAY YEAR January 29, 1984			2b. HOUR 3:05A M	
3. SEX Male,		4. RACE White,		5. DATE OF BIRTH MONTH DAY YEAR December 18, 1945		6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction		12b. KIND OF BUSINESS OR INDUSTRY Building Cons.	
13a. STATE Maryland		13b. COUNTY - -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Herman K. Durden				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evader - Blanks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO - -		16b. SOCIAL SECURITY NO. 214-44-6426		17. INFORMANT ADDRESS Mrs. Evader B. Durden 105 S. Washington St. (21231)			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Liver Failure****5714**

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Chronic Active Hepatitis**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**2 years**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) this hospital attended the deceased from January 3, 19 84 , to January 29, 19 84 , the XXX (we) lost saw the deceased alive on January 29, 19 84 , and that in XX (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.							
22b. SIGNATURE Helen E. Downs				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/29/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Helen E. Downs, M.D.				22e. ADDRESS c/o Maryland General Hospital			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 31, 1984		23c. NAME OF CEMETERY OR CREMATORY OakLawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE - - Baltimore Co., Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave./21231				25a. DATE REC'D. BY REGISTRAR FEB 2 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Bristol Jan. 31, 1984 Oaklawn Cemetery - - - Baltimore Co., Md.

John H. Brown, M.D. c/o Maryland General Hospital

1/22/84

January 20 84 K
January 2 84 XX
January 29 84 KXX

X

Chronic Active Hepatitis

2 years

Liver Failure

NO

- -

2124-0026

Mrs. Evelyn B. Dugan 107 S. Washington St.

James

K.

Dugan

Evelyn

Brian

Ma yland

- -

Baltimore

X

107 S. Washington St. (1111)

Baltimore

Harland General Hospital

Construction

Baltimore Co.

West Carolina United States

United States

Baltimore City

Male

White

December 18, 1983

X

BURDEN

I.

Donald

January 29, 1984 2:05A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

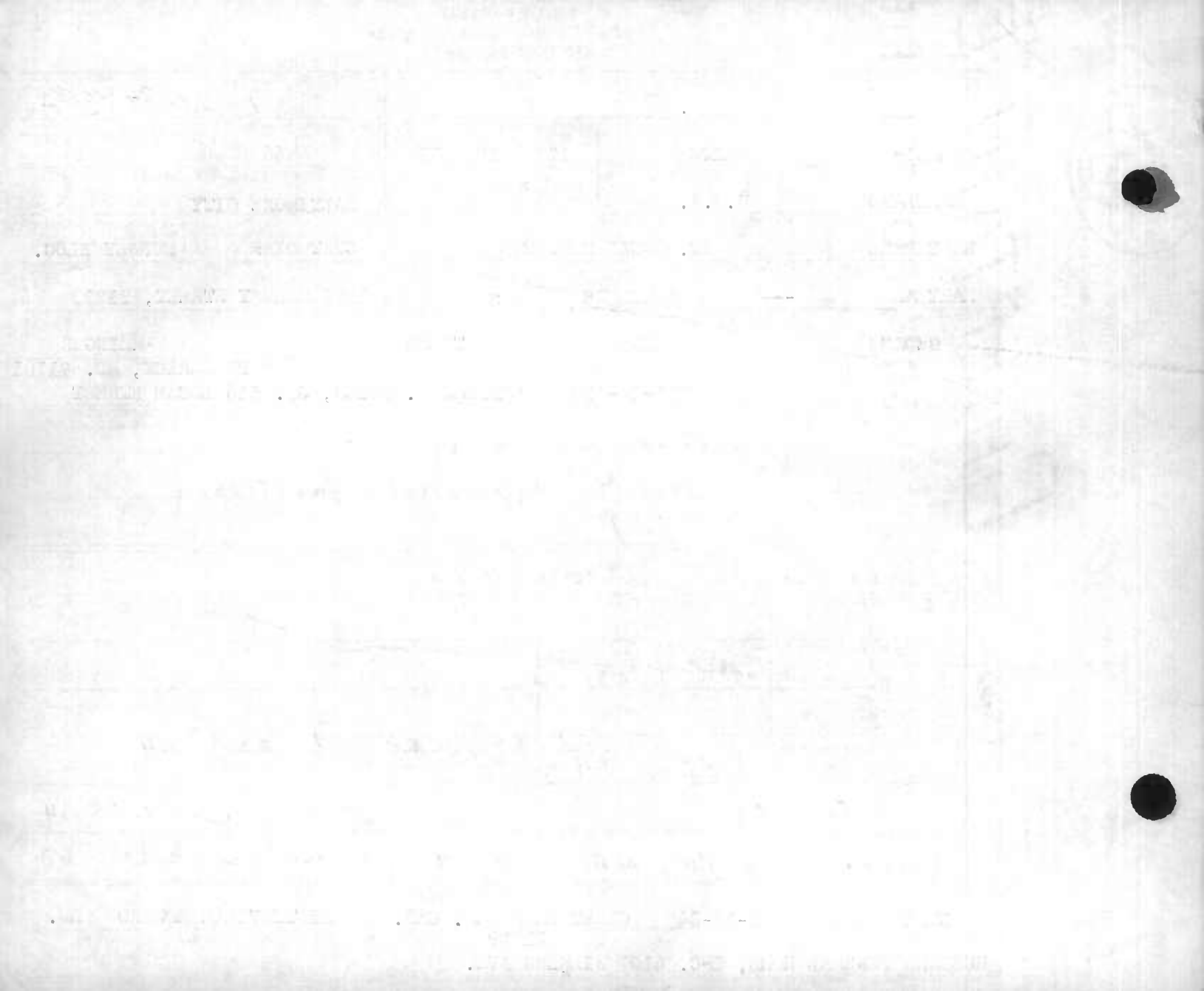
1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EVA L. DWYER			2a. DATE OF DEATH MONTH DAY YEAR 1-28-84			2b. HOUR 358A M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 19 17		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CUSTODIAN		12b. KIND OF BUSINESS OR INDUSTRY MUNSEY BLDG.	
13a. STATE MARYLAND		13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1335 RAMSAY STREET, 21223	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE KING				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MATILDA ARMINGER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES NO		16b. SOCIAL SECURITY NO. 213-34-3304		17. INFORMANT ADDRESS FREDERICK, MD. 21701 CHARLES E. DWYER, JR. 516 LOGAN STREET					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory arrest 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Possible Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Insulin dependent Diabetes Mellitus -									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR (A.M. OR P.M.) MONTH DAY YEAR 358 P.M. 1/28/1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1.25. 1984 to 1.28. 1984 , that (I) (we) last saw the deceased alive on 1.28. 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE QUANG NGOC TU, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1.28.84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS ST. AGNES HOSPITAL, BALT., MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 01-31-84		23c. NAME OF CEMETERY OR CREMATORY CREST LAWN MEM. GAR.		23d. LOCATION CITY OR TOWN COUNTY STATE MARRIOTTSTVILLE HOWARD MD.			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.				ADDRESS 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR JAN 30 1984		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 7 2 5

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
LESTER DYER			January 30, 1984			11:40a			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
MALE		WHITE		MONTH DAY YEAR 01 17 23		61 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
TENNESSEE		U.S.A.				BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		ST. AGNES HOSPITAL				CABINET MAKER		WESTINGHOUSE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE					13d. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS / ZIP CODE					
MARYLAND		BALTIMORE		223 CLYDE AVENUE, 21227					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST				FIRST MIDDLE LAST					
JOHN DYER				MABEL ELLIS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
YES				WW II		MARION DYER 223 CLYDE AVENUE, 21227			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
4100 IMMEDIATE CAUSE (a) Myocardial infarction									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Renal failure. S/P Auto-Fem By Pass									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
12/13/83			Severe Vascular Insuff lower ext			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK									
22a. I certify that (I) (this hospital) attended the deceased from 12/11/83 to 12/30/84, that (I) (we) lost saw the deceased alive on 19, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		22c. DATE SIGNED		
B. Parandian					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		1/30/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
B. PARANDIAN, M.D.					3455 WILKENS AVENUE, 21229				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL			02-02-84		MARYLAND VETERANS CEM.		CROWNSVILLE, A.A. MARYLAND		
24. FUNERAL DIRECTOR NAME					ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		
HUBBARD FUNERAL HOME, INC.					4107 WILKENS AVE.		FEB 1 1984 John J. Carney		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examiner's certificate must be filed with this certificate.

BP



Handwritten text, possibly a signature or date, appearing upside down.

Handwritten text, possibly a signature or date, appearing upside down.

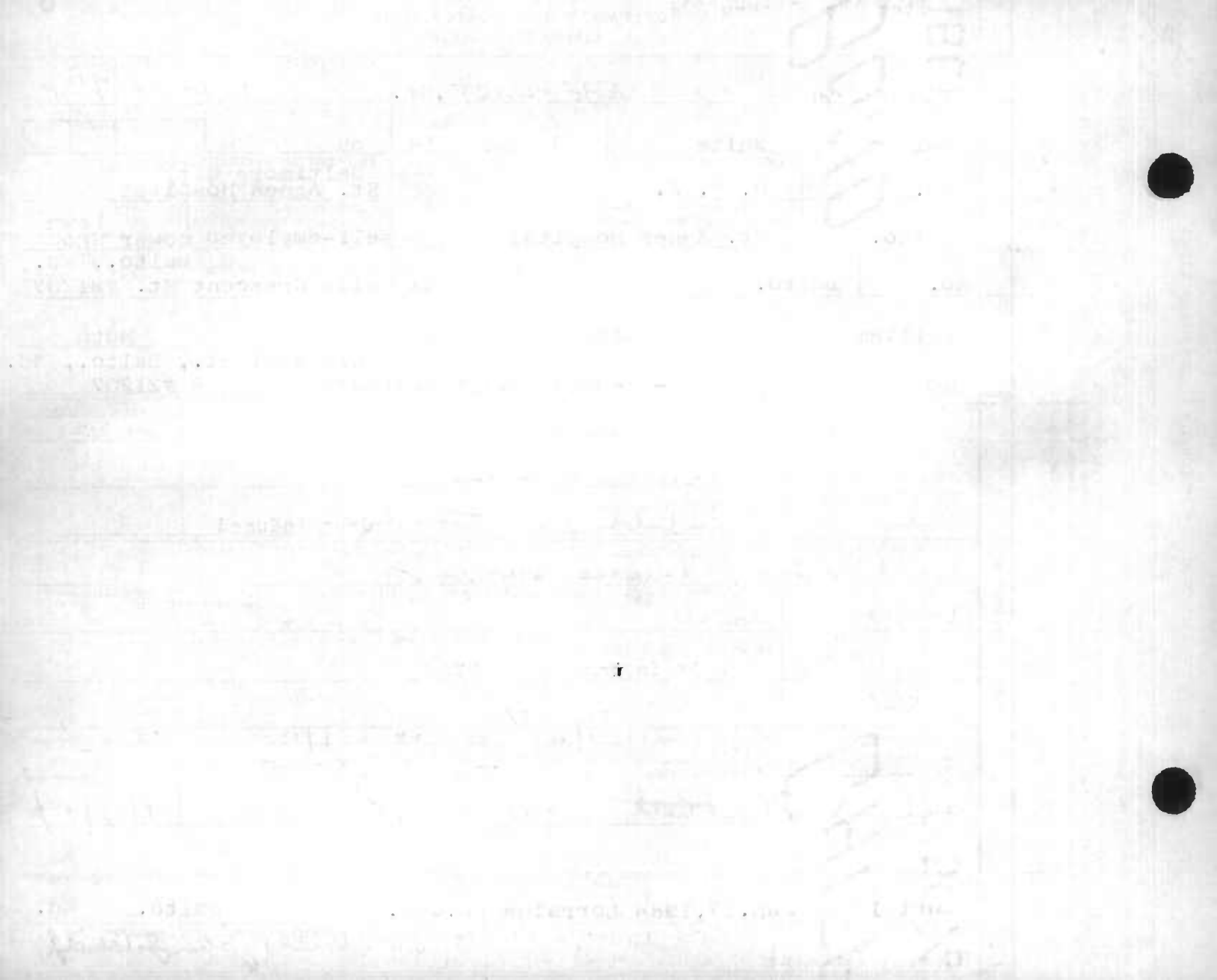
Handwritten text, possibly a signature or date, appearing upside down.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon-copy. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) WILLIAM F. EBERHART, Sr.					2a. DATE OF DEATH MONTH DAY YEAR 1 13 84			2b. HOUR 7:18 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 31 14		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City St. Agnes Hospital MD.					
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) self-employed			12b. KIND OF BUSINESS OR INDUSTRY Lawn Mower Shop		
13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Balto., Md.		13d. STREET ADDRESS / ZIP CODE 5126 Crescent St. #21207				
14. FATHER'S NAME FIRST MIDDLE LAST William Eberhart					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Muth						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-07-9288		17. INFORMANT Evelyn Eberhart ADDRESS 5126 Crescent St., Balto., Md. #21207						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio-negative Sepsis 2849 DUE TO, OR AS A CONSEQUENCE OF (b) Aplastic Anemia DUE TO, OR AS A CONSEQUENCE OF (c) Probable drug toxicity Drug Induced Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Recent Coronary Bypass Surgery											
19a. DATE OF OPERATION 12/15/83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ASCVD			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. No injury 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) N/A					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> WHILE NOT AT WORK <input type="checkbox"/> N/A			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A			21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A					
22a. I certify that (I) (this hospital) attended the deceased from 1/2 , 19 84 , to 1/13 , 19 84 , that (I) (we) last saw the deceased alive on 1/13/84 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Natural											
22b. SIGNATURE Stephen J. Plantthatt					DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/13/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 17, 1984		23c. NAME OF CEMETERY OR CREMATORY Lorraine Pk. Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR NAME G. Truman Schwab					ADDRESS 5151 Balto. Nat'l. P.K. #21229		25. DATE REC'D. BY REGISTRAR JAN 20 1984		25b. REGISTRAR'S SIGNATURE [Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Frederick W. Eckels								January 12, 1984		4:15AM	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		MONTH DAY YEAR 5 2 07		76 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore City MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Maryland General Hospital						Accountant		Steel	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		733 S. Potomac Street 21224			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Paul William Eckels				FIRST MIDDLE LAST Margaret Roth							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		212-03-8387A		Mrs. Lillian M. Eckels,		733 S. Potomac St. Baltimore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest											
2501 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Diabetic Ketoacidosis											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
Pre-Leukemic Syndrome, Prostatic Carcinoma											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 11, 19 84, to January 12, 19 84, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 12, 19 84, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Laura J. Decker				MD				1-12-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Laura J. Decker, M.D.				c/o Maryland General Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Entombment		1-16-84		Moreland Mem. Park		Baltimore		Baltimore		Md.	
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Nicholas I. Matthews, 3021 Eastern Avenue Baltimore, Md.						JAN 19 1984		John J. Connelley			

BP 9

1934: January 11, 1934

1934: January 11, 1934

1934: January 11, 1934

1934: January 11, 1934

1934: January 11, 1934

1934: January 11, 1934

1934: January 11, 1934

1934: January 11, 1934

1934: January 11, 1934

1934: January 11, 1934

1934: January 11, 1934

1934: January 11, 1934

1934: January 11, 1934

1934: January 11, 1934

1934: January 11, 1934

1934: January 11, 1934

1934: January 11, 1934

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR AT 5 ME (1))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH		2b. HOUR	
James E. Edwards										1 1 1984		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR		
Male	Black	10 6 13		70 YRS.					1 1 1984		1:20 a		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Virginia		U.S.A.					Baltimore City, MD.						
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore				Union Memorial Hospital									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2627 Greenmount Ave. 21218					
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME			
Robert		H.		Edwards		Martha		E.		Chappell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO				216-01-7347		Anna Sharpe		Apt. 313 1600 Mt. Royal Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u> 9654 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
12:50xx 1 1 19 84				Subject shot									
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
delicatessen						2627 Greenmount Ave, Balto.						Md	
22a. I certify that I took charge of the informant described above. Held on: Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
Thomas D. Smith, M.D.				Deputy Chief				1/1/84					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
Thomas D. Smith, M.D.				111 Penn St. Balto., MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN							
BURIAL		1/7/84		Mount Auburn Cem.		Baltimore, MD.							
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Wm C March F/H Inc, 1101 E North Avenue				JAN 3 1984				John J. [Signature]					

UNION

ACTIO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARL HENRY EGER			2a. DATE OF DEATH MONTH DAY YEAR 1 7 84		2b. HOUR 8:45 p.m.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR April 10, 1915	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC BALTIMORE, MD. 21218		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer-Tin Mill	12b. KIND OF BUSINESS OR INDUSTRY Steel Mfg.	
13a. STATE MARYLAND		13b. COUNTY BALTO.	13c. CITY OR TOWN DUNDALK	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST THEODORE EGER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE RIDDER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WWII		16b. SOCIAL SECURITY NO. 226.12.5589	17. INFORMANT ADDRESS STEWART A. MILLER 9812 GAMBEL AVE. GARDEN GROV E, CALIF. 92641		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest 4275 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) pulmonary/respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): exanthema					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED (R) hip fracture		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 15, 1983 to JANUARY 7, 1984 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on JANUARY 7, 1984 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.					
22b. SIGNATURE Eric A. Wiebke MD		DEGREE MD		22c. DATE SIGNED 1/8/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERIC A. WIEBKE MD		22e. ADDRESS LOCH RAVEN VA HOSP BALT MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/11/1984	23c. NAME OF CEMETERY OR CREMATORY RED HOUSE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE RED HOUSE GARRETT MARYLAND
24. FUNERAL DIRECTOR WALTER BROOKS BRADLEY, INC., DUNDALK, MD. 21222			25a. DATE REC'D. BY REGISTRAR JAN 9 1984		25b. REGISTRAR'S SIGNATURE John J. Conner

BP _____

7



ВНЕШНЕКОСМАН
ОБЩЕСТВО



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) DR. STUART WILSON EGERTON					2a. DATE OF DEATH MONTH DAY YEAR January 7, 1984			2b. HOUR 400 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 15, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician		12b. KIND OF BUSINESS OR INDUSTRY Medical	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10 Beechdale Road 21210	
14. FATHER'S NAME FIRST MIDDLE LAST Stuart Egerton					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha White				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW I		17. INFORMANT ADDRESS 220 44 2465 Elizabeth F. Egerton,			18. Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CORONARY ARTERY DISEASE</u> (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>PERIPHERAL VASCULAR DISEASE - PACEMAKER INSERTION</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>1/7</u> , 19 <u>84</u> , to <u>1/7</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>1/7</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Miguel Karacuschansky</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1-9-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Miguel Karacuschansky, M.D.					22e. ADDRESS Union Memorial Hospital, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/10/84		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD		
24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212					25a. DATE REC'D. BY REGISTRAR JAN 9 1984		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>		

UNITED STATES DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF MEDICAL SERVICE

1. Name: [illegible]
2. Grade: [illegible]
3. Branch: [illegible]
4. Date: [illegible]

5. Service Number: [illegible]
6. Station: [illegible]
7. Duty Station: [illegible]
8. Remarks: [illegible]

9. Signature: [illegible]
10. Date: [illegible]
11. Remarks: [illegible]

12. Remarks: [illegible]
13. Remarks: [illegible]
14. Remarks: [illegible]
15. Remarks: [illegible]

16. Remarks: [illegible]
17. Remarks: [illegible]
18. Remarks: [illegible]
19. Remarks: [illegible]
20. Remarks: [illegible]

21. Remarks: [illegible]
22. Remarks: [illegible]
23. Remarks: [illegible]
24. Remarks: [illegible]
25. Remarks: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDWARD P. EICHELBERGER			2a. DATE OF DEATH MONTH DAY YEAR 1-23-84			2b. HOUR 9:36 AM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 9 20 64		6. AGE (IN YEARS, MONTHS, DAYS) 19 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 1 23		7b. IF UNDER 24 HRS HOURS MIN. 9 36	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed			12b. KIND OF BUSINESS OR INDUSTRY Painter		
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3317 Northway Dr. - 21234			
14. FATHER'S NAME FIRST MIDDLE LAST John Frank Eichelberger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie C. Leimbach							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW II 215-05-0263		17. INFORMANT ADDRESS Mary C. Eichelberger - Same as #13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4860 DUE TO, OR AS A CONSEQUENCE OF (b) Meningitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 7 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>1/17</u> , 19 <u>84</u> , to <u>1/23</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>1/23</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jeffrey Kirsch MD						DEGREE MD		22c. DATE SIGNED 1-23-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey Kirsch MD						22e. ADDRESS Good Samaritan Hospital Johns Hopkins Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-25-84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.						ADDRESS 1050 York Rd. Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR JAN 24 1984		25b. REGISTRAR'S SIGNATURE John J. Leimbach	

BP



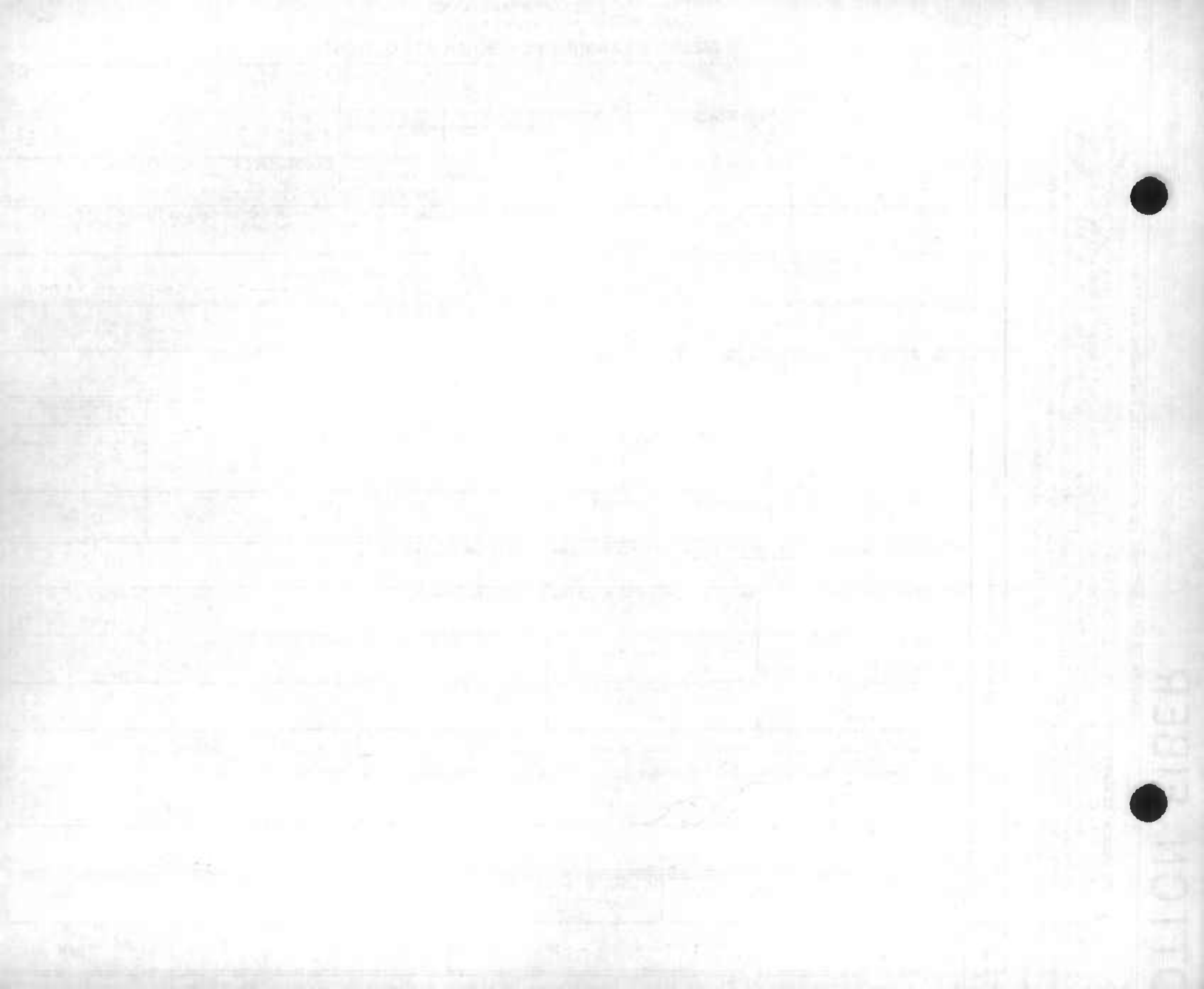
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2b. DATE KNOWN OF DEATH		<input type="checkbox"/> MONTH	DAY	YEAR	2d. HOUR
JAMES LOUIS ELEY					1 11 19 84					M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD	
Male	Black	12 24 28		55 YRS.	MONTHS DAYS HOURS MIN.				1 12 19 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.					Baltimore City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		619 Bartlett Ave.								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		619 Barclay Street 21218		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST				FIRST MIDDLE LAST						
Bruce Eley				Mineva Ward						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
NO				231-26-8865		James H. Eley		2523 E. Chase Street		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Hypertensive & arteriosclerotic cardiovascular disease</u>										
4029										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										
(b) _____										
DUE TO, OR AS A CONSEQUENCE OF										
(c) _____										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
		HOUR A.M. MONTH DAY YEAR								
		P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION						
				STREET CITY OR TOWN COUNTY STATE						
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED		
				M.D. Assistant				1-12-84		
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS						
Ann M. Dixon, M.D.				111 Penn St., Balto., Md. 21201						
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY		
BURIAL		1/16/84		Mount Calvary Cem.		Anne Arundel Co.		Md.		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Wm C March F/H Inc. 1101 E North Avenue				JAN 13 1984						

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. MONTH			2c. DAY			2d. YEAR			2e. HOUR		
Thomas J. Ellenberger			1			28			1984								
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR	7. IF UNDER 24 HRS.	8. DATE PRONOUNCED DEAD			9. BALTIMORE CITY OR COUNTY OF DEATH			10. HOUR			11. DATE		
M	W	4/31/84	59 YRS.			1			28 1984			3:44			P M		
12. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			13. CITIZEN OF WHAT COUNTRY?			14. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			15. BALTIMORE CITY OR COUNTY OF DEATH								
Baltimore			—						Baltimore City								
16. CITY OR TOWN OF DEATH			17. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			18. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)			19. KIND OF BUSINESS OR INDUSTRY								
Baltimore			Baltimore City Hospital			Longhmanick Work											
20. USUAL RESIDENCE (IF IN HUSBAND'S HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			21. STATE			22. COUNTY			23. CITY OR TOWN			24. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			25. STREET ADDRESS		
Md.			—			Baltimore			YES			1312 Hull St					
26. FATHER'S NAME (FIRST, MIDDLE, LAST)			27. MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST)			28. INFORMANT			29. ADDRESS								
John J. Ellenberger			Jessie Curry			Thor J. Ellenberger			Baltimore, Md. 21230								
30. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			31. SOCIAL SECURITY NO.			32. INFORMANT			33. ADDRESS								
Yes			W.H. Illing 218-12-733			Thor J. Ellenberger			1312 Hull St								
34. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4292																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
35a. DATE OF OPERATION						35b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						36. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
37a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						37b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						37c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
38a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						38b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						38c. LOCATION STREET CITY OR TOWN COUNTY STATE					
39. I certify that I took charge of the remains described above, held on death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE						TITLE (SPECIFY) M.D. Deputy Chief						DATE SIGNED 1/29/84					
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS						111 Penn St. Balto., Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY					
Entombment						2/1/84						Cedar Hill Cemetery					
24. FUNERAL DIRECTOR						25. DATE REC'D. BY REGISTRAR						26. REGISTRAR'S SIGNATURE					
CHARLES L. SPURKS FUNERAL HOME INC.						JAN 30 1984						John J. Carver					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

 DHMH - 17
 (VR A15 ME (15))
 20M 4/82



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 3 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDWARD ELLIS			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 20, 1984			2b. HOUR 11:00A			
3 SEX Male		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 2 1883		6. AGE (IN YEARS LAST BIRTHDAY) 100 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Fred Ellis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Ellis			13e. STREET ADDRESS / ZIP CODE 1838 E. Lafayette Avenue 21213			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 217-05-3404		17. INFORMANT Abraham Monk			ADDRESS 7515 Inwood Avenue		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 0389 IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis / lactic acidosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 MIN 2 DAYS								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 	
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/14 , 19 84 , to 1/20 , 19 84 , that (I) (we) last saw the deceased alive on 1/20 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M. S. Runge				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/20/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. S. RUNGE				22e. ADDRESS Johns Hopkins Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPRING) BURIAL		23b. DATE 1/25/84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills, Md.			
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR JAN 23 1984		25b. REGISTRAR'S SIGNATURE John J. Connel			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a physician or completed by a funeral director, it should be detached for use in the burial transit permit. Then please remove carbon papers. Pages 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as true, it shows any injury, or other traumatic event, the physician or funeral director should be notified.

BP

008 55 78

二二

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 3 5

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARY			2a. DATE OF DEATH MONTH DAY YEAR 1 2 1984			2b. HOUR 2 15 PM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 24 1939		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO City MD.			
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV OF MD HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 804 FULTON AVE BALTO 21217	
14. FATHER'S NAME FIRST LAST JAMES BENNET				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY STARKS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 216 34 3396		17. INFORMANT ADDRESS Mr. John Ellis 1801 Barclay St 21202					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/27 1983 to 1/2 1984 , that (I) (we) last saw the deceased alive on 1/2 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Salvaterra MD				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/2/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SALVATERRA				22e. ADDRESS UNIV OF MD HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/9/84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Va.Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Baltimore Md.			
24. FUNERAL DIRECTOR NAME JOSEPH L. RUSS				ADDRESS 2222 W. North Ave		25a. DATE REC'D. BY REGISTRAR JAN 12 1984		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 48 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

BP

11 FEB 1948
[Faint handwritten notes and stamps at the top of the page]

11 FEB 1948
[Faint handwritten notes and stamps in the middle section]

11 FEB 1948
[Faint handwritten notes and stamps in the lower middle section]

11 FEB 1948
[Faint handwritten notes and stamps at the bottom of the page]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Inez Ellison			2a. DATE OF DEATH MONTH DAY YEAR January 22, 1984			2b. HOUR 4:15A M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 3 04		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 79		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21217 727 Druid Park Lake Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Blackwell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Diggs					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES NO				16b. SOCIAL SECURITY NO. 212-30-5164		17. INFORMANT ADDRESS Julia A. Johnson 4122 Westchester Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Probable New Onset Right Cardiovascular Accident DUE TO, OR AS A CONSEQUENCE OF (c) Right Cerebral Meningioma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 Minutes 1 Week									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: History of Myocardial Infarction With Congestive Heart Failure; Starvation									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I; OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 19, 1984 to January 22, 1984 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 22, 1984 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death.									
22b. SIGNATURE Richard L. Loria M.D.						DEGREE M.D.		22c. DATE SIGNED 1-22-84	
22d. PHYSICIAN'S NAME Richard Loria, M.D.						22e. ADDRESS c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1/27/84		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md.		
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue						25a. DATE REC'D. BY REGISTRAR JAN 23 1984		25b. REGISTRAR'S SIGNATURE John J. Loria	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.



FROM: 151A
DATE: January 22, 1984
TO: Allison

Baltimore City

Mr. and Mrs. General

General

151A

General

General

On the 22nd of January 1984

General

General

Index of General

151A
January 22, 1984

151A

General

General



151A



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.		
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		
			FIRST MIDDLE LAST RUBX J. EMEKICK.		MONTH DAY YEAR 11/18/84		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
F		W		MONTH DAY YEAR 10 18 1935		88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia		U.S.A				Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTO		LA FAYETTE SQUARE		TEXTILE WORK		MILLS	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST ? ? ?		FIRST MIDDLE LAST ? ? ?		No		212-01-9443	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
James M. MacDonald 3023 Kenwood Rd		Arterio Sclerotic Heart Disease		Many years			
		(b) DUE TO, OR AS A CONSEQUENCE OF					
		4140		Atrial Fibrillation			
		(c) DUE TO, OR AS A CONSEQUENCE OF					
		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
		COPD, old CVA, Hypertension					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		22c. DATE SIGNED			
above, (I) (we) (did) (did not) view the body after death.		DEGREE		1-1-84			
		M.D.		1-2-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE			
SHANKAT Y. K. HAN		1528 King William Drive, Balto, MD 21218		Paul A. Chinneth 3615-19 Chestnut Ave			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		1-4-84		Lorraine Park		Balto MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME		JAN 3 1984		Chen & Connel			



Handwritten notes and a table at the top of the page. The table has several columns and rows, with some cells containing numbers and others containing text. The handwriting is somewhat faded and difficult to read.

Handwritten notes and a table in the middle of the page. The table has several columns and rows, with some cells containing numbers and others containing text. The handwriting is somewhat faded and difficult to read.

Handwritten notes and a table at the bottom of the page. The table has several columns and rows, with some cells containing numbers and others containing text. The handwriting is somewhat faded and difficult to read.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. FOR STATE REGISTRAR LUREAH MARIE EMMINIZER												
1. DECEASED NAME (TYPE OR PRINT) Lured Marie Emminizer					2a. DATE OF DEATH MONTH DAY YEAR 1-4-84							
3. SEX Female					4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Oct. 5, 1918		2b. HOUR 1:52 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky			7b. CITIZEN OF WHAT COUNTRY? U.S.		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.			8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Gen. Hosp.					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor Eastern Blinds			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY A. A.		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 4140 Annapolis Rd., Apt. 1B (21227)	
14. FATHER'S NAME FIRST MIDDLE LAST James Milton Sanders					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Helen Williams							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 218-22-3234		17. INFORMANT ADDRESS Marvin Emminizer (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary Arrest 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Cancer of Breast (c) Pulmonary edema										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Renal failure												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1-1 , 19 84 , to 1-4 , 19 84 , that (I) (we) lost saw the deceased alive on 1-4 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Martin G. Guerrero MD					DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-4-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Martin G. Guerrero					22e. ADDRESS 3001 So. Hanover st							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) ENTOMBMENT			23b. DATE Jan. 7, 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk., A.A.Co., Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS George J. Gonce, 4001 Ritchie Hg., Baltimore					25a. DATE REC'D. BY REGISTRAR JAN 4 1984		25b. REGISTRAR'S SIGNATURE John J. Gough					

BP _____



[Faint, illegible text and markings across the page, possibly bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be buried within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by doctor.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		01 05 84		3:52 PM	
DOROTHY L ENTERLINE							
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
Female		White		April 10, 1903		80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Pennsylvania		U.S.A.				BALTIMORE CITY, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		THE JOHNS HOPKINS HOSPITAL		Home Maker		Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Pennsylvania		Dauphin		Harrisburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS / ZIP CODE		99999	
Henry Welker		Lucetta Unknown		5600 Stradford Avenue		17112	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		208-42-5961		Lee H. Enterline		Harrisburg, Pennsylvania	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)	
2501		Cardiorespiratory Arrest		Profound Metabolic acidosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 mins 6 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:		Diabetes Mellitus, Urinary tract Infection, Terminal heart disease, Renal Failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
12/30/83		Choroidal hemorrhage 3636		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) (this hospital) attended the deceased from 11/5/84 to 12/31/83, to 1/5/84, that (ii) (we) last saw the deceased alive on 1/5/84, and that (iii) (our) opinion death occurred on the date and hour and from the causes stated above (i) (we) (did) (did not) view the body after death.		22b. SIGNATURE Paul Katzenstein		DEGREE MD		22c. DATE SIGNED 1/5/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. LOCATION CITY OR TOWN COUNTY STATE			
KATZENSTEIN		Johns Hopkins Hospital		Harrisburg, Pennsylvania			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Jan. 9, 1984		Woodlawn Mem. Gardens		Harrisburg, Pennsylvania	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ruck Towson Funeral Home, Inc.		1050 York Road Towson, Md. 21204		JAN 9 1984		John S. Lauer	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) SAMUEL FRANK EPHRAIM					2a. DATE OF DEATH MONTH DAY YEAR JANUARY 8, 1984			2b. HOUR 11 A. M.				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 10, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.						
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1190 W. NORTHERN PARKWAY, APT. 402				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT		12b. KIND OF BUSINESS OR INDUSTRY RETAIL				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1190 W. NORTHERN PARKWAY, APT. 402 (21210)	
14. FATHER'S NAME FIRST MIDDLE LAST RALPH L. EPHRAIM				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE FRANK								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-05-9453		17. INFORMANT ADDRESS MRS. BETSY E. HAAS APT. 402 (21210) 1190 W. NORTHERN PARKWAY								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C. Disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10920		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> 1093												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>1967</u> 19____, to <u>1/8</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.												
22b. SIGNATURE <u>Edward S. Kallins</u> <u>MD</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/9/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. EDWARD KALLINS						22e. ADDRESS 6000 PARK HEIGHTS AVE.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1/10/84		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW CEM			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND				
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215						25a. DATE REC'D. BY REGISTRAR JAN 17 1984			25b. REGISTRAR'S SIGNATURE <u>John J. Lohr</u>			

BP _____



[Faint, mostly illegible handwritten text on lined paper. Some words like 'The', 'and', 'of' are visible.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.				
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		2a. DATE KNOWN OF ESTI. DEATH MATED		MONTH	DAY	YEAR	2b. HOUR	
		FTHEL M. EPPS						<input checked="" type="checkbox"/> 1-20-84				19	M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR
Female	Black	1 9 21		63 YRS.					1-20-84				19	8:41A
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
Virginia		U.S.A.				Baltimore City								MD.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Baltimore		1738 McKean Street												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS						
Maryland				Baltimore				3210 Elgin Avenue				21216		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
Samuel		Beatrice Campbell		UNKNOWN		212-24-8575		Jennie Handy		101 Doral Court				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a). <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c).													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?										
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED										
Margarita A. Korell		M.D. Assistant		1-20-84										
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY				
Margarita A. Korell, M.D.		111 Penn Street		BURIAL		1/27/84		King Memorial Park		Randallstown, Md.				
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
F/H		Wm C March Inc. 1101 E North Avenue		JAN 24 1984		John J. Connel								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR MIN.			
JOSEPHINE EPPS				JAN. 30/84 11 45 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		BLACK		4/12/11		72 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
S. Carolina		U.S.A.				Balt. City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Balt.		Bon Secours Hosp.					
13a. STATE		13b. COUNTY		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS	
Maryland				Baltimore		729 N. Carey Street 21217	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
John Price				Sarah Ruth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
NO		218-22-9932		Robert Epps 3232 Presstman Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Acute Myocardial Infarction							
4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute Pulmonary Edema							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Cardiomyopathy							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Ch. Obstructive Lung Disease; Seizure Disorder							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 1/30, 1984, to 1/30, 1984, that (I) (we) lost (saw, then deceased) (saw or above, (we) (do) (did not) view the body after death.							
22b. SIGNATURE (Physician's Name) (Type or Print)		DEGREE		ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
HERNANDEZ GONZALEZ JR		MD		2000 W. Baltimore		1/30/84	
23a. BURIAL, CREMATION, REMOVAL () BURIAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
		2/4/84		Mount Auburn Cem.		Baltimore, Md.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
Wm C March F/H Inc, 1101 E North Avenue				FEB 1 1984 John J. [Signature]			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84 00943
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) SHIRLEY M ERBY			2a. DATE OF DEATH MONTH DAY YEAR 01 04 84		2b. HOUR 6:22P
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR May 3, 1956	6. AGE (IN YEARS LAST BIRTHDAY) 27 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. USA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beautician	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. CITY OR TOWN Marlow Hgts.	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 4201 28th Avenue, B-3 20031

14. FATHER'S NAME FIRST MIDDLE LAST Morris Brown	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Mae Sellars
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. 579 47 9265
17. INFORMANT ADDRESS Mrs. Joanne Hancock-sister-406 Balboa Avenue, Capitol Heights, Maryland	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2051 IMMEDIATE CAUSE (a) Cardio pulmonary arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Hepatorenal syndrome		
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Myelogenous Leukemia		

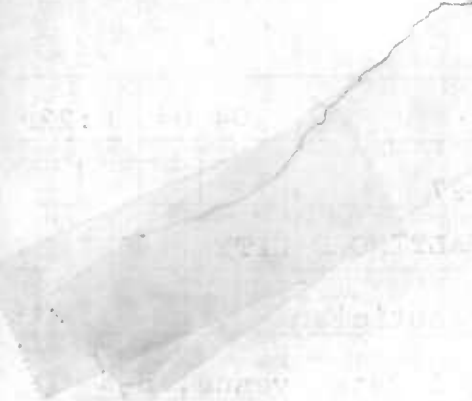
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11c.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/17 , 19 83 , to 1/4 , 19 84 , that (I) (we) lost saw the deceased alive on 1/4 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Robert Weiss	DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 1/4/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT WEISS		22e. ADDRESS Johns Hopkins Hospital Balt Md 212	

23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE Jan. 9, 1984	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park	23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Md.
24. FUNERAL DIRECTOR Stewart Funeral Home-4001 Benning Rd.,		25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE JAN 13 1984	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



OFFICE
ST. LOUIS, MO.

RECEIVED
ST. LOUIS, MO.
JAN 10 1904

46/31 X

ST. LOUIS, MO. JAN 10 1904

ST. LOUIS, MO. JAN 10 1904

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <i>Josephine C. Esteridge</i>					2a. DATE OF DEATH MONTH DAY YEAR HOUR <i>1 27 84 3:16 P.M.</i>				
3. SEX <i>4</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>July 4 1925</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>58</i>		7. IF UNDER 1 YEAR MONTHS DAYS <i></i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore, MD.</i>			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>John L. Deaton Medical Center</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Waitress</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1 W. Conway street 21201</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Robert Early Brown</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sally Blanche Shuoraft</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>277-20-5282</i>		17. INFORMANT <i>Sr. Pierre</i>		ADDRESS <i>8800 Harford Rd.</i>			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the lung with cerebral metastases.</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Celiac Disease.</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <i>11/8</i> , 19 <i>83</i> , to <i>1/27</i> , 19 <i>84</i> , that (we) last saw the deceased alive on <i>1/27</i> , 19 <i>84</i> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>David Leichter</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>1/27/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DAVID LEICHTLING</i>			22e. ADDRESS <i>John L Deaton BALT MD 21230</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>1-30-1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Moreland Memorial</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Md.</i>		
24. FUNERAL DIRECTOR NAME <i>Leonard J. Ruck, Inc</i>					ADDRESS <i>5395 Harford Rd.</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 30 1984</i>		
					25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>				

BP

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

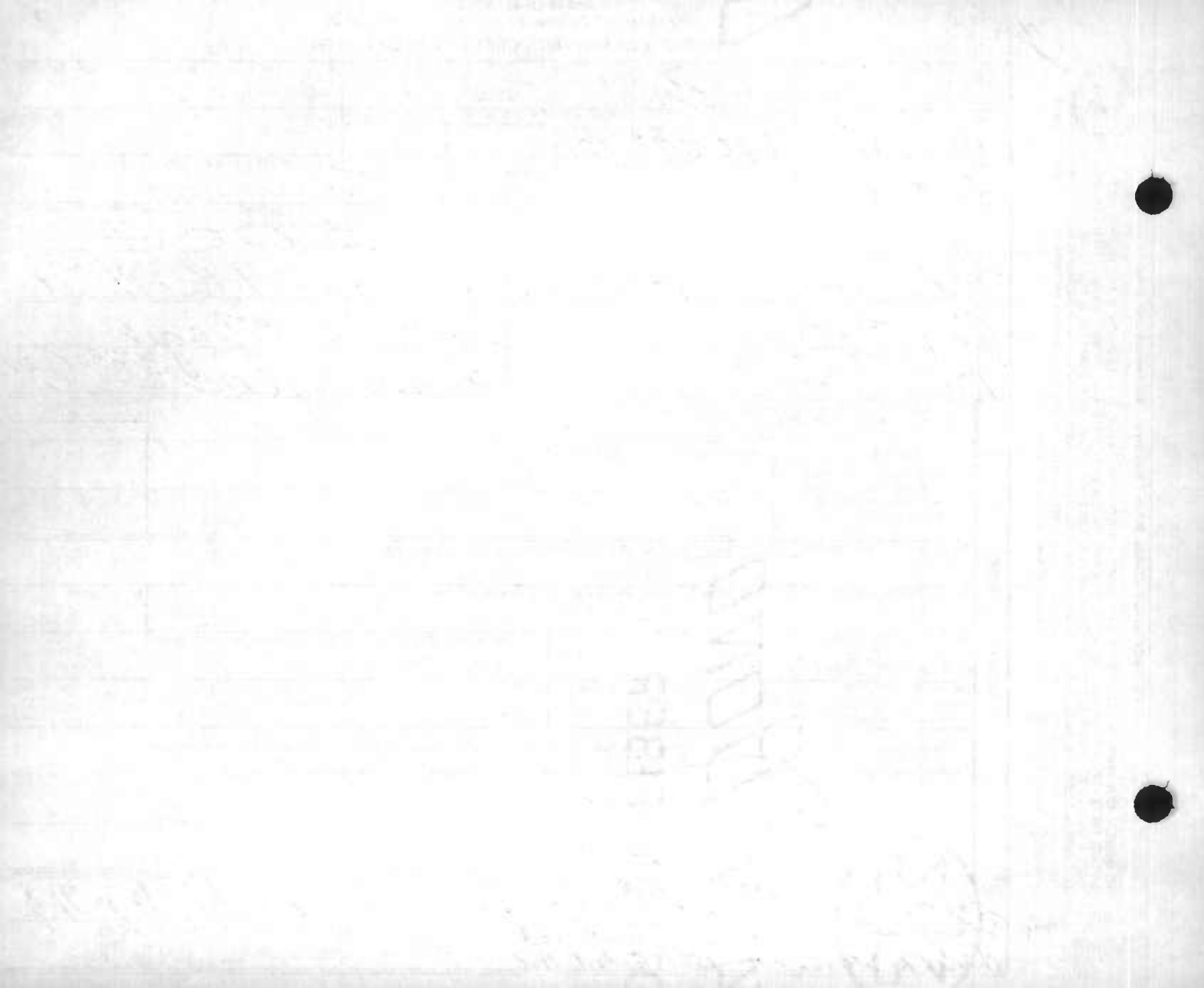
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF KNOWN ESTI- DEATH MATED		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR			
Michael		Estep						<input type="checkbox"/> 1		3		19		84		M			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR			
M.	W	Sept 27 73		10 YRS.						1		3		19		84			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. COUNTRY OF BIRTH		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										4:25A			
Baltimore				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore City,										M			
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		University Hospital		Student															
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS											
Baltimore				Baltimore				823 31 Cross St.											
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)																	
Ray Estep		Anna Mae Vogel																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No				William Vogel		1706 Larma													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Smoke and soot inhalation and acute carbon</u> 8902 Conditions, if any, which gave rise to immediate cause (b) stating the under- lying cause last. <u>monoxide intoxication</u> DUE TO, OR AS A CONSEQUENCE OF (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:37xx 1 3 1984				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) House fire											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 823 W. Cross St. Balto., MD.											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accidental <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE				TITLE (SPECIFY) Deputy Chief				MEDICAL EXAMINER				DATE SIGNED 1/3/84							
EXAMINER'S NAME (TYPE OR PRINT)				Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto, MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE 1/6/84				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Dr. Peter H. Hall, Jr.							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Charles L. Stevens F.H.				1501 E. Fort Ave				JAN 5 1984				John J. Carling							

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 4 6

FOR
STATE
REGISTRAR

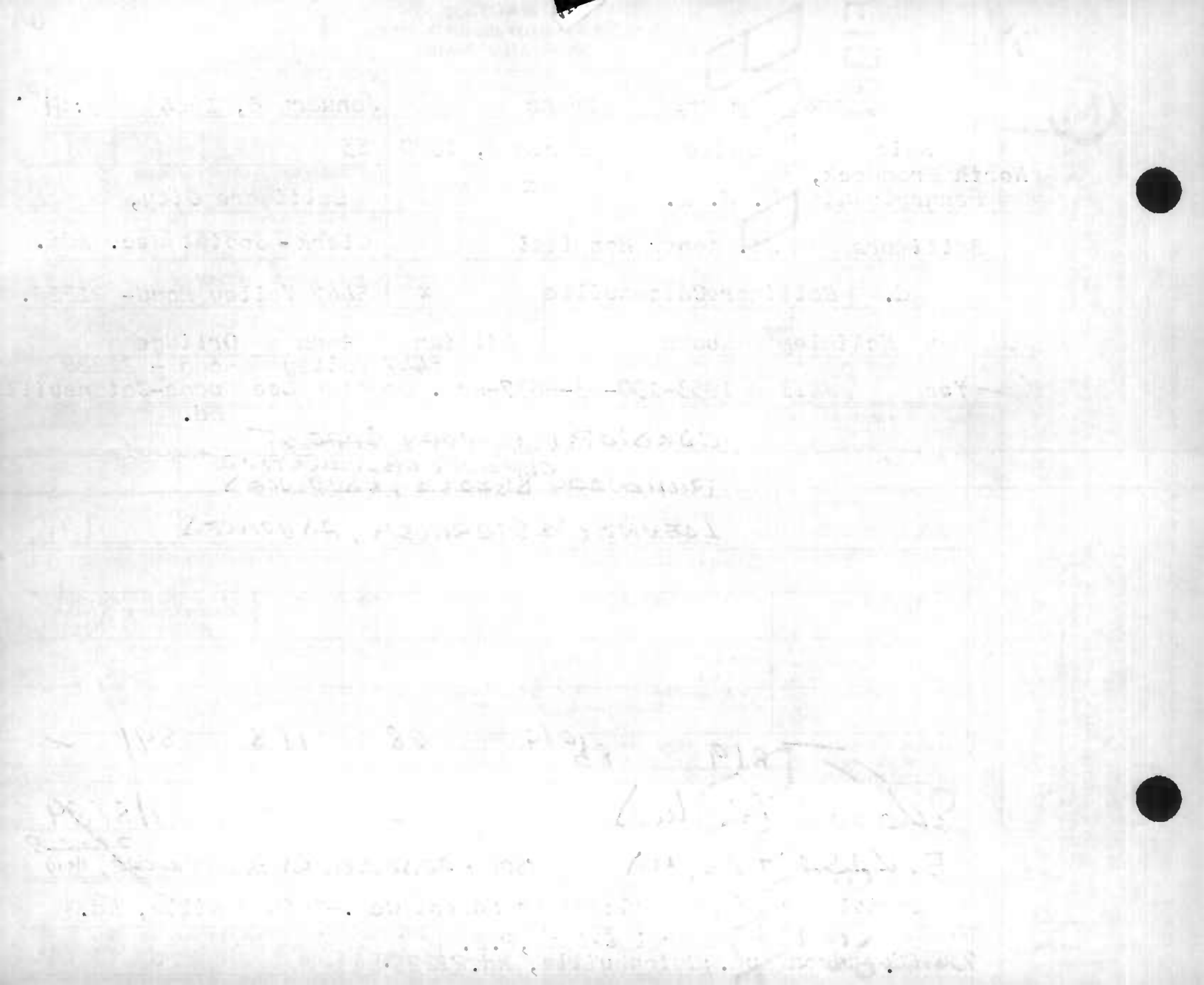
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Raymond Harry Evans			2a. DATE OF DEATH MONTH DAY YEAR January 8, 1984			2b. HOUR 5:41 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 8, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 63		7. IF UNDER 1 YEAR MONTHS DAYS YRS.	
8. PLACE OF BIRTH (COUNTRY) North Braddock, Pennsylvania		9. CITIZEN OF WHAT COUNTRY? U. S. A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
12. CITY OR TOWN OF DEATH Baltimore		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk - Social		15. KIND OF BUSINESS OR INDUSTRY Sec. Adm.	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Md.			16b. CITY Baltimore		16c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16d. STREET ADDRESS / ZIP CODE 5447 Valley Road - 21228.		
17. FATHER'S NAME FIRST MIDDLE LAST Ray McKinley Evans			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Anna Orlidge			19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			
20. SOCIAL SECURITY NO. WWII & 1953-190-03-9638			21. INFORMANT 5447 Valley Road - 21228			22. Mrs. Dorothy Lee Evans-Catonsville			
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) CARDIO-PULMONARY APPET. DUE TO, OR AS A CONSEQUENCE OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE, ADVANCED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LAENNEC'S CIRRHOSIS, ADVANCED DUE TO, OR AS A CONSEQUENCE OF: (c) LAENNEC'S CIRRHOSIS, ADVANCED									24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MD.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)									
25. DATE OF OPERATION			26. CONDITION FOR WHICH OPERATION WAS PERFORMED			27. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
32. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			34. LOCATION STREET CITY OR TOWN COUNTY STATE			
35. I certify that (I) (this hospital) attended the deceased from 8/19 19 83 to 11/8 19 84 , that (I) (we) last saw the deceased on 8/19 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.									
36. SIGNATURE E. KASATIS, M.D.			37. DEGREE MD			38. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		39. DATE SIGNED 1/8/84	
40. PHYSICIAN'S NAME (TYPE OR PRINT) E. KASATIS, M.D.			41. ADDRESS 1801 FREDERICK RD, BALTIMORE, MD			42. ZIP CODE 21228			
43. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			44. DATE 1/11/84		45. NAME OF CEMETERY OR CREMATORY Garrison Forest Cem.		46. LOCATION CITY OR TOWN COUNTY STATE OWINGS Mills, Md.		
47. FUNERAL DIRECTOR NAME ADDRESS Sterling Funeral Estate, P.A. 736 Edmondson Ave.; Catonsville, Md. 21228					48. DATE REC'D. BY REGISTRAR 21 JAN 1984		49. REGISTRAR'S SIGNATURE John J. Smith		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

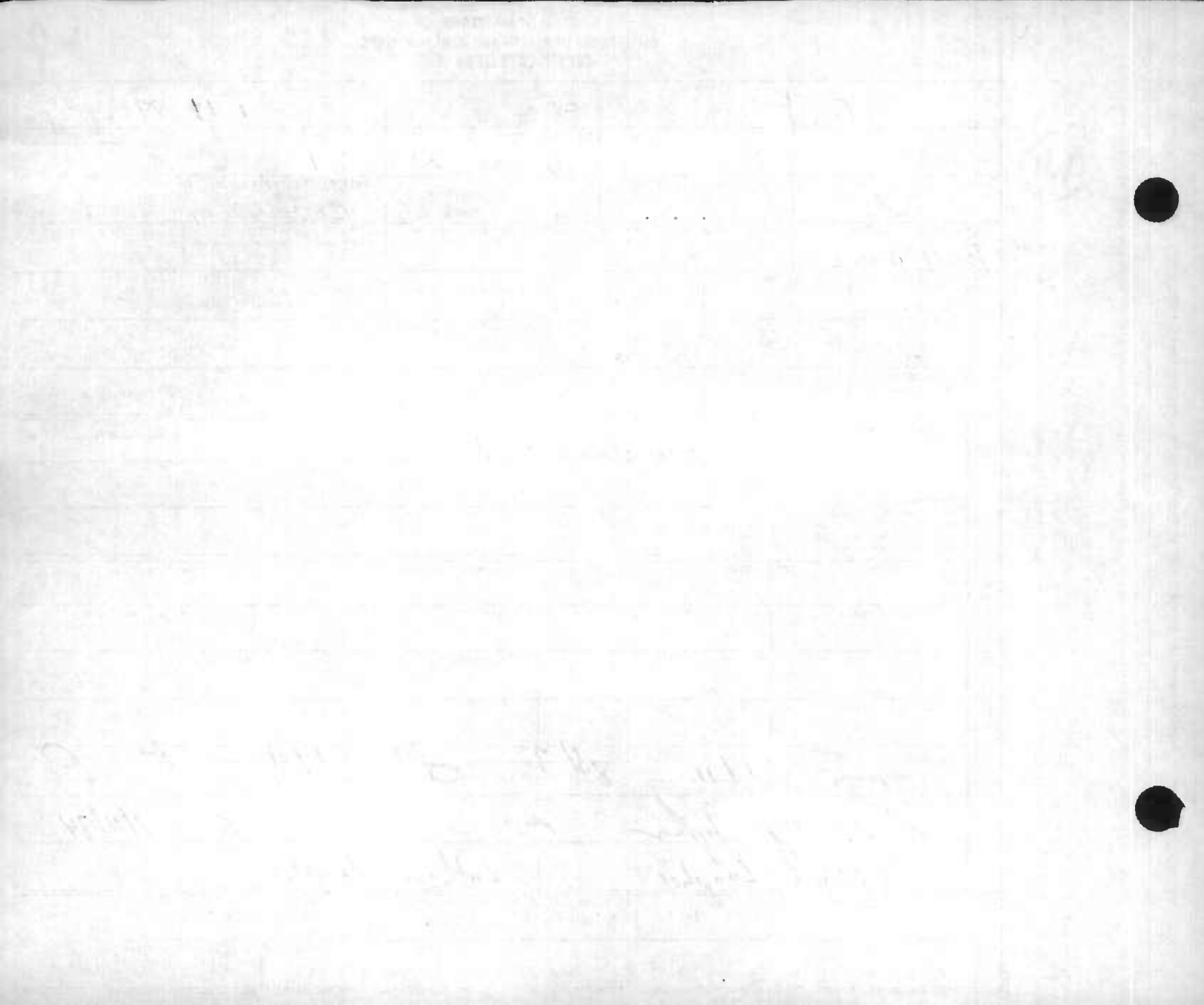
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST David	MIDDLE	LAST Evans	2a. DATE OF DEATH		MONTH 1	DAY 17	YEAR 84	2b. HOUR 9:24 PM	
3. SEX M	4. RACE B	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City, MD					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Apt. 1101 21217 717 Druid Park Lake Drive	
14. FATHER'S NAME FIRST Davis				MIDDLE		LAST Evans		15. MOTHER'S MAIDEN NAME FIRST Tina		MIDDLE McFadden	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 171-16-0984		17. INFORMANT ADDRESS Louis Evans 3414 Cedardale Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> 4275 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/11/84</u> to <u>1/11/84</u> , that (I) (we) last saw the deceased alive on <u>1/11/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Gregory J. Lapher</u>				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/11/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregory J. Lapher				22e. ADDRESS Lutheran Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/16/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION Anne Arundel Co., Md.			
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue						25a. DATE REC'D. BY REGISTRAR JAN 13 1984		25b. REGISTRAR'S SIGNATURE <u>John G. Lapher</u>			

BP



Items #15-22a 4/18/84 mtb R#590 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE KNOWN OF DEATH ESTI- MATED			MONTH DAY YEAR			22. HOUR			
JOHN EVANS						1-14-84			19			4:56a			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YR.		8. IF UNDER 24 HRS.		21. DATE PRONOUNCED DEAD		22. HOUR	
Male		Black		4 10 41		42 YRS.						1-14-84		19	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia				U.S.A.								Baltimore City			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				bench-east side of S. Caroline St. unit block											
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Maryland								Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
Otis				Mattie				UNKNOWN							
17. INFORMANT				ADDRESS				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Bland-Reed F/H				413 Eley Street				3419							
19. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
								CITY OR TOWN				COUNTY			
								STATE							
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
Margarita A. Korell, M.D.				Assistant				1-14-84							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE			
Margarita A. Korell, M.D.				111 Penn Street				BURIAL				1/30/84			
								23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
								Sharon Cemetery				Cumberland, Va.			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Wm C March F/H Inc.				1101 East North Ave.				FEB 1 1984				John J. Conner			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

3

DATE

EX-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Fannie Ewell						2a. DATE OF DEATH MONTH DAY YEAR January 29, 1984		2b. HOUR P 5:20 M	
2. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 30 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York, N. Y.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Teacher		12b. KIND OF BUSINESS OR INDUSTRY Balto. City Schools			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2019 Madison Ave. Baltimore, Maryland 21217			
14. FATHER'S NAME FIRST MIDDLE LAST William Eskridge				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Henritta Parker				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 214-40-4895				17. INFORMANT ADDRESS Sara Gwaltney Ave. Baltimore, Md. 21216				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Chest Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June , 19 1983 to January 29 , 19 84 , that (I) (we) lost saw the deceased alive on January 29 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sew the body after death.											
22b. SIGNATURE Marsha Brown, M.D.				DEGREE MD				22c. DATE SIGNED 1/30/84		22d. ADDRESS 5400 Old Court Road	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Marsha Brown, M.D.				22f. ADDRESS 5400 Old Court Road				22g. DATE REC'D. BY REGISTRAR FEB 1 1984		22h. REGISTRAR'S SIGNATURE John J. Conner	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2/3/1984		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Nutter & Sons				ADDRESS 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216				25. REGISTRAR'S SIGNATURE John J. Conner			



January 29, 1984 2:30

Black 8 30 1980
 New York, N.Y. U.S.A.
 Baltimore City

Baltimore
 Maryland General Hospital
 N. E. C. Teacher
 Baltimore, Maryland 21215

214-60-4893
 2400 W. Interstate
 Baltimore, Md. 21215

Handwritten notes:
 Are you sure?
 Baltimore

221-3838
 2400 Old Court Road
 N. D.
 2/3/82
 2501 Gwynns Falls Expy.
 Baltimore, Maryland 21215

Baltimore, Maryland
 General Home Inc.
 Baltimore, Maryland 21215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ROBERT FALLIN				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR JANUARY 01 23 84 10 30 PM			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 06 06 01		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOME & HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAINTER		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN ROSEDALE				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6416 KENWOOD AVE. 21237	
14. FATHER'S NAME FIRST MIDDLE LAST HARDIN FALLIN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE DODSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 244162590		17. INFORMANT ADDRESS LULA FALLIN 6416 KENWOOD AVE.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Edema 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Brain Carcinoma (Glioma) DUE TO, OR AS A CONSEQUENCE OF (c) -							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs 10 mos
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Chronic lung Disease, Hypertension							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2524 GUILFORD RD BALTO BALTO MD.			
22a. I certify that (I) (this hospital) attended the deceased from Jan 10 1984 , to Jan 23 1984 , that (I) (we) lost saw the deceased alive on Jan 23 1984 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							22c. DATE SIGNED 1/23/84
22b. SIGNATURE Vikas Saini				DEGREE MD		22c. DATE SIGNED 1/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIKAS SAINI				22e. ADDRESS 100 NORTH BROADWAY 21231 CHURCH HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/26/84		23c. NAME OF CEMETERY OR CREMATORY gardens of faith		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO BALTO MD.	
24. FUNERAL DIRECTOR NAME Chasaco				ADDRESS 1211 Chasaco Ave		25a. DATE REC'D. BY REGISTRAR JAN 25 1984	
				25b. REGISTRAR'S SIGNATURE John J. Carver			

BP

2201 W 3 10/25/31 12345 12345

SS NO 00 00 1234567890
1234567890 1234567890 1234567890
1234567890 1234567890 1234567890
1234567890 1234567890 1234567890

1234567890 1234567890 1234567890
1234567890 1234567890 1234567890
1234567890 1234567890 1234567890
1234567890 1234567890 1234567890

1234567890 1234567890 1234567890
1234567890 1234567890 1234567890
1234567890 1234567890 1234567890
1234567890 1234567890 1234567890

1234567890 1234567890 1234567890
1234567890 1234567890 1234567890
1234567890 1234567890 1234567890
1234567890 1234567890 1234567890

1234567890 1234567890 1234567890
1234567890 1234567890 1234567890
1234567890 1234567890 1234567890
1234567890 1234567890 1234567890

1234567890 1234567890 1234567890
1234567890 1234567890 1234567890
1234567890 1234567890 1234567890
1234567890 1234567890 1234567890

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84 00951

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Arthur C. Fanwell</i>			2a. DATE OF DEATH MONTH DAY YEAR 1 16 84		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 27 08		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital 21218		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Oscar Fanwell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Myers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-09-1691		17. INFORMANT ADDRESS Mrs. Eleanor Fanwell 3704 Hickory Ave. 21211	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>
2500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cong Heart Failure</i>		<i>years</i>
(c) <i>Diabetes</i>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *0*

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>1981</i> to <i>1/16</i> , 19 <i>84</i> , that (I) (we) lost <i>1/14</i> , 19 <i>84</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Richard L Diamond</i>		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>1/16/84</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>RICHARD L DIAMOND</i>		22e. ADDRESS <i>3547 CHESTNUT AVE BALT MD 21211</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/18/84	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gdns	23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Maryland
--	----------------------	--	---

24. FUNERAL DIRECTOR NAME ADDRESS A. Alan Seitz, Jr. 3818 Roland Avenue 21211	25a. DATE REC'D. BY REGISTRAR JAN 23 1984	REGISTRAR'S SIGNATURE <i>John J. Conner</i>
---	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 4 0 0 9 5 2				
1- FOR STATE REGISTRAR					CERTIFICATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
Farmer Baby Boy					1 8 84				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
male		White		1 8 84		1 8 84		Am M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. BALTIMORE CITY	
Maryland		U.S.A.				Baltimore City		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		St. Agnes Hospital		N/A		N/A			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		-		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5045 S. Payson Street 21223	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
(unknown)		(unknown)		No		N/A		Deborah Farmer Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7729				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
DUE TO, OR AS A CONSEQUENCE OF (b) CNS BLEEDING, POSSIBLE									
DUE TO, OR AS A CONSEQUENCE OF (c) Extreme Prematurity									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
		P.M. 19							
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE OF OPERATION		21h. CONDITION FOR WHICH OPERATION WAS PERFORMED		21i. HOW INJURY OCCURRED		21j. PLACE OF INJURY	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR	
Amos MacRae, M.D.		1/8/84		ARTHUR L. MACARAETH, M.D.		ST. AGNES HOSPITAL		FEB 14 1984	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. REGISTRAR'S SIGNATURE	
Burial		2/14/84		New Cathedral Cemetery		Baltimore Md.		Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 5 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHLOE Ruth FAUTH			2a. DATE OF DEATH MONTH DAY YEAR 1 14 84			2b. HOUR 11:14 A.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 2 16 14		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hosp 3001 S. Hanover St				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) NC		13b. COUNTY Avery		13c. CITY OR TOWN Newland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt 2 Box 56 28654	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph A. Ledford				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Blackburn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218 22 8944		17. INFORMANT Mr. William Fauth		ADDRESS Same as #13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4100

IMMEDIATE CAUSE (a) **cardiovascular shock**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

days

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last(b) **acute myocardial infarction**

1 week

DUE TO, OR AS A CONSEQUENCE OF

(c) **arteriosclerotic cardiovascular disease**

long standing

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

severe pulmonary fibrosis

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/20 , 19 83 , to 1/14 , 19 84 , that (I) (we) last saw the deceased alive on 1/14 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dorothea A. Steen md				DEGREE		22c. DATE SIGNED 1/14/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dorothea A. Steen md				22e. ADDRESS 3001 S. Hanover Street Balto, Md, 21230			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 1/15/1984		23c. NAME OF CEMETERY OR CREMATORY Tate Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pineola, Avery Co., N. C.	
24. FUNERAL DIRECTOR NAME Reins-Sturdivant F.H. ADDRESS Newland, N.C. 28657 Linville St.				25a. DATE REC'D. BY REGISTRAR JAN 24 1984		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in its entirety, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1891

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) SARAH F. FELDMANN			2a. DATE OF DEATH MONTH DAY YEAR JAN. 29 1984		2b. HOUR 1:00 P.M.
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JUNE 20 1896		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEONINAVE HEBREW GERIATRIC CENTER + HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS APT. 2F 3603 LABYRINTH RD. NW
14. FATHER'S NAME FIRST MIDDLE LAST JACOB FRANK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA SACHS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 216-56-7045		17. INFORMANT DAVID O. FELDMANN 6305 WINNER AVE. BALTO., MD 21215	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

1539 IMMEDIATE CAUSE (a) **METASTATIC COLONIC CA**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

SP. RT. HEMICOLECTOMY, ASBY w/ HISTORY OF MI + ANGINA

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 1/29 , 19 83 , to 1/29 , 19 84 , that (we) last saw the deceased alive on 1/29 , 19 84 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (if we) (did) (not) view the body after death.					
22b. SIGNATURE Estrelita O. Ku, MD		DEGREE MD		22c. DATE SIGNED 1/29/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESTRELITA O. KU, MD		22e. ADDRESS LEONINAVE HEBREW GERIATRIC CENTER + HOSPITAL			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE JAN. 30, 1984	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW	23d. LOCATION BALTIMORE COUNTY MARYLAND
24. FUNERAL DIRECTOR NAME Bob Levinson 500 REISTER TOWN		25. DATE REC'D. BY REGISTRAR FEB 1 1984	
26. REGISTRAR'S SIGNATURE John J. Smith		27. REGISTRAR'S SIGNATURE John J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		XX MONTH DAY YEAR		2b. HOUR M	
Gwendolyn						Fenner		1-20		19 84		8:30 p. M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		7d. HOUR M	
FEMALE	BLACK	05 31 57		26 YRS.						1-20 19 84			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
md.		U.S.A.						Baltimore City, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		701 W. Mulberry St., Apt. 1010						Unemployed					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
md.				BALTO.				701 W. MULBERRY ST. 21201					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
LEVI		CAWLOW		GLORIA FENNER									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS									
NO				MS. GLORIA FENNER - 405 HEAVER ST.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stab Wounds of Neck 9660 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 8:15 P.M. 1-20 19 84				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was stabbed					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 701 W. Mulberry St., Apt. 1010. Balto., Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 1-21-84					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
Dennis F. Smyth, M.D.				111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		1-27-84		KING MEM. PARK				RANDALLS TOWN md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR									
Redd FUNERAL HOME		5209 YORK RD. 21212		JAN 26 1984									
				25b. REGISTRAR'S SIGNATURE									
				John J. Carver									

OFFICIAL USE

NOV 1964

11/11/64

(11/11/64)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE. IF THE DELAY IS MORE THAN 24 HOURS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 72 HOURS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 10 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 30 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 90 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 180 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 360 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 720 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 1440 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 2880 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 5760 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 11520 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 23040 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 46080 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 92160 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 184320 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 368640 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 737280 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 1474560 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 2949120 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 5898240 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 11796480 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 23592960 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 47185920 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 94371840 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 188743680 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 377487360 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 754974720 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 1509949440 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 3019898880 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 6039797760 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 12079595520 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 24159191040 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 48318382080 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 96636764160 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 193273528320 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 386547056640 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 773094113280 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 1546188226560 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 3092376453120 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 6184752906240 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 12369505812480 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 24739011624960 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 49478023249920 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 98956046499840 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 197912092999680 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 395824185999360 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 791648371998720 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 1583296743997440 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 3166593487994880 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 6333186975989760 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 12666373951979520 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 25332747903959040 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 50665495807918080 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 101330991615836160 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 202661983231672320 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 405323966463344640 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 810647932926689280 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 1621295865853378560 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 3242591731706757120 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 6485183463413514240 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 12970366926827028480 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 25940733853654056960 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 51881467707308113920 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 103762935414616227840 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 207525870829232455680 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 415051741658464911360 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 830103483316929822720 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 1660206966633859645440 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 3320413933267719290880 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 6640827866535438581760 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 13281655733070877163520 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 26563311466141754327040 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 53126622932283508654080 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 106253245864567017308160 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 212506491729134034616320 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 425012983458268069232640 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 850025966916536138465280 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 1700051933833072276930560 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 3400103867666144553861120 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 6800207735332289107722240 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 13600415470664578215444480 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 27200830941329156430888960 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 54401661882658312861777920 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 108803323765316625723555840 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 217606647530633251447111680 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 435213295061266502894223360 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 870426590122533005788446720 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 1740853180245066011576893440 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 3481706360490132023153786880 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 6963412720980264046307573760 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 13926825441960528092615147520 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 27853650883921056185230295040 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 55707301767842112370460590080 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 111414603535684224740921180160 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 222829207071368449481842360320 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 445658414142736898963684720640 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 891316828285473797927369441280 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 178263365657094759585473882560 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 356526731314189519170947765120 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 713053462628379038341895530240 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 1426106925256758076683791060480 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 2852213850513516153367582120960 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 5704427701027032306735164241920 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 11408855402054064613470328483840 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 22817710804108129226940656967680 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 45635421608216258453881313935360 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 91270843216432516907762627870720 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 182541686432865033815525255741440 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 365083372865730067631050511482880 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 730166745731460135262101022965760 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 1460333491462920270524202045931520 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 2920666982925840541048404091863040 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 5841333965851681082096808183726080 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 11682667931703362164193616367452160 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 23365335863406724328387232734904320 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 46730671726813448656774465469808640 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 93461343453626897313548930939617280 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 186922686907253794627097861879234560 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 373845373814507589254195723758469120 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 747690747629015178508391447516938240 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 149538149525803035701678289503387680 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 299076299051606071403356579006775360 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 598152598103212142806713158013550720 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 1196305196206424285613426316027101440 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 2392610392412848571226852632054202880 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 4785220784825697142453705264108405760 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 9570441569651394284907410528216811520 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 19140883139302788569814821056433623040 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 38281766278605577139629642112867246080 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 76563532557211154279259284225734492160 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 153127065114422308558518568451468984320 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 306254130228844617117037136902937968640 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 612508260457689234234074273805875937280 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 1225016520915378468468148447611751874560 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 2450033041830756936936296953223503749120 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 4900066083661513873872593906447007498240 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 9800132167323027747745187812894014996480 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 1960026433464605549549037562578802999360 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 3920052866929211099098075125157605998720 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 7840105733858422198196150250315211997440 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 15680211467716844396392300500630423994880 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 31360422935433688792784601001260847989760 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 62720845870867377585569202002521695979520 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 125441691741734755171138404005043391959040 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 250883383483469510342276808010086783918080 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 501766766966939020684553616020173567836160 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 1003533533933878041369107232040347135672320 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 2007067067867756082738214464080694271344640 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 4014134135735512165476428928161388542689280 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 8028268271471024330952857856322777085378560 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 16056536542942048661905715712645554170757120 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 32113073085884097323811431425291108341514240 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 64226146171768194647622862850582216683028480 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 12845229234353638929524572570116443336605760 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 25690458468707277859049145140232886673211520 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 51380916937414555718098290280465773346423040 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 102761833874829111436196580560935546692846080 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 205523667749658222872393161121871093385692160 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 411047335499316445744786322243742186671384320 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 822094670998632891489572644487484373342768640 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 164418934199726578297914528897496874668553600 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 328837868399453156595829057794993749337107200 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 657675736798906313191658115589987498674214400 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 1315351473597812626383316231179974997348428800 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 2630702947195625252766632462359949994696857600 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 5261405894391250505533264924719899989393715200 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 10522811788782501011066529849439799978787430400 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 21045623577565002022133059698879599957574860800 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 42091247155130004044266119397759199915149721600 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 84182494310260008088532238795518399830299443200 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 168364988620520016177064477591036799660598886400 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 336729977241040032354128955182073599321197772800 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 673459954482080064708257910364147198642395545600 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 1346919908964160129416515820728294397284791091200 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 2693839817928320258833031641456588794569582182400 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 5387679635856640517666063282913177589139164364800 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 10775359271713281035332126565826355178278328729600 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 21550718543426562070664253131652710356556657459200 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 43101437086853124141328506263305420713113314918400 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 86202874173706248282657012526610841426226629836800 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 172405748347412496565314025053221682852453259673600 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 344811496694824993130628050106443365704906519347200 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 689622993389649986261256100212886731409813038694400 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 137924598677929997252251220042577346281962607738880 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 275849197355859994504502440085154692563925215477760 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 551698394711719989009004880170309385127850430955520 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 1103396789423439978018009760340618770255700861911040 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 2206793578846879956036019520681237540511401723822080 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 4413587157693759912072039041362475081022803447644160 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 8827174315387519824144078082724950162045606895288320 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 17654348630775039648288156165449900324091213790576640 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 35308697261550079296576312330899800648182427581153280 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 70617394523100158593152624661799601296364855162306560 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 141234789046200317186305249323599202592729710324613120 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 282469578092400634372610498647198405185459420649226240 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 564939156184801268745220997294396810370918841298452480 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 1129878312369602537490441994588793620741837682596904960 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 2259756624739205074980883989177587241483675365193809920 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 4519513249478410149961767978355174482967350730387619840 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 9039026498956820299923535956710348957934701460775239680 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 18078052997913640599847071913420697915869402921550479360 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 36156105995827281199694143826841395831738805843100958720 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 72312211991654562399388287653682791663477611686201917440 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 144624439823309124798776575307365583326955223372403834880 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 289248879646618249597553150614731166653910446744807669760 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 578497759293236499195106301229462333307820893489615339520 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 1156995518586472998390212602458924666615641786979230679040 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 2313991037172945996780425204917849333231283573958461358080 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 4627982074345891993560850409835698666462567147916922716160 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 9255964148691783987121700819671397332925134295833845432320 DAYS, PLEASE ADVISE THE DIVISION OF VITAL RECORDS BY TELEPHONE AND MAIL. IF THE DELAY IS MORE THAN 18511928297383

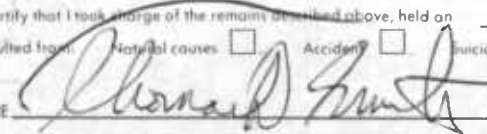



CLIC LIT

AND

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) John Henry Fenwick							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1 29 1984		2b. HOUR M		
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 11 10 55		6. AGE (IN YEARS) LAST BIRTHDAY 28 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 1 29 1984	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
11. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1100 Blk Woodyear Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21201 812 Edmondson Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST N/A				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Fenwick							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Pearl S. Fenwick 927/W. Woodyear St					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9654 IMMEDIATE CAUSE (a) Gunshot wound of chest & abdomen DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:33xx 1 29 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject shot					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1100 Blk Woodyear St, Balto, Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 1/29/84			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St.				BALTO, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/3/84		23c. NAME OF CEMETERY OR CREMATORY Eastview Mem Park				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md			
24. FUNERAL DIRECTOR NAME ADDRESS William C. March F/H 1101 E. North Ave						25a. DATE REC'D. BY REGISTRAR JAN 31 1984		25b. REGISTRAR'S SIGNATURE 			

MEDICAL CERTIFICATION

RECEIVED
JAN 10 1964
U.S. AIR FORCE
HEADQUARTERS
WASHINGTON, D.C.

1



15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Inez E. Ferrar					2a. DATE OF DEATH MONTH DAY YEAR January 20, 1984			2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 31, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 7709 Windy Ridge				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY 13c. CITY OR TOWN Baltimore					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7709 Windy Ridge 21234		
14. FATHER'S NAME FIRST MIDDLE LAST Michael Capobianco					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angela Rainone				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 118-10-9767		17. INFORMANT ADDRESS Arthur Ferrar 7709 Windy Ridge 21234		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a). Heart Attack DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Meningioma									
19a. DATE OF OPERATION 10/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Meningioma				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/21/83 to 11/21/83, that (I) (we) last saw the deceased alive on 4/21/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John B. Posey III, M.D.					DECEASED ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John B. Posey III, M.D.					22e. ADDRESS 201 E. University Parkway Baltimore, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 23, 1984		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Leonard J. Buck, Inc. Baltimore, Md.					25a. DATE REC'D. BY REGISTRAR JAN 24 1984		25b. REGISTRAR'S SIGNATURE John J. Connel		

BP _____

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked **deceased**, it indicates any injury, or other traumatic event, or medical condition that caused death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ALVIN C. FEY			2a. DATE OF DEATH MONTH DAY YEAR January 10, 1984		2b. HOUR 3:20 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 26, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long Green Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY US Gov't.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Balto.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3 E. 33rd St. 21218	
14. FATHER'S NAME FIRST MIDDLE LAST ? Fey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ?				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577 58 1529		17. INFORMANT ADDRESS Wayne A. Fey, California 90266		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>CONGESTIVE HEART FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>CORONARY ARTERY DISEASE</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ANEMIA - ATRIAL FIBRILLATION</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>10/22</u> , 19 <u>83</u> , to <u>1/10</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>10/22</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Mig Karacuschansky</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-11-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Miguel Karacuschansky, M.D.		22e. ADDRESS 300 E. 33rd St., Balto., MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/17/84	23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chicago, Illinois		
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212		25a. DATE REC'D. BY REGISTRAR JAN 17 1984		25b. REGISTRAR'S SIGNATURE <u>Ben J. Conner</u>		

BP

RECEIVED
JAN 10 1964

January 10, 1964

FEY

1/10

Jan 25, 1960

White

White

USA

USA

U.S. Govt.

Long Green Laundry Center

Baltimore

x

Baltimore

MD

Fly

3

677 88 1028 E. Ave., Baltimore, MD

No

OFFICE
OF THE
DIRECTOR
OF
INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

Mr. W. J. Jenkins, Director, Federal Bureau of Investigation, U.S. Department of Justice, Washington, D.C.

Re: [illegible] - [illegible] - [illegible]

Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above.

Very truly yours,
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the back, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William A. Fialkowski Jr.			2a. DATE OF DEATH MONTH DAY YEAR 1-13-84		2b. HOUR 7:46pm	
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 7-10-63		6. AGE (IN YEARS LAST BIRTHDAY) 20 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) App. Dir. + Emb.		12b. KIND OF BUSINESS OR INDUSTRY FUNERAL Home
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William A. Fialkowski Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jeanne L. Stahle		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		
16b. SOCIAL SECURITY NO. 213-52-4936		17. INFORMANT ADDRESS WM. A. FIALKOWSKI, SR. 1769 STOKESLEY RD., BALTO. MD. 21222				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 2051 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myelomonocytic Leukemia DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Rhonda A. Richards, M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-13-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. M.J. Feldman		22e. ADDRESS 3001 S. Hanover				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-17-84		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART OF JESUS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. BALTO MD.
24. FUNERAL DIRECTOR NAME Wm. Fialkowski, Jr.		24b. ADDRESS 2001 E. STERN AVE. (S. Hanover)		25a. DATE REC'D. BY REGISTRAR JAN 17 1984		25b. REGISTRAR'S SIGNATURE John J. Canfield

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 6 1

1- FOR
STATE
REGISTRAR

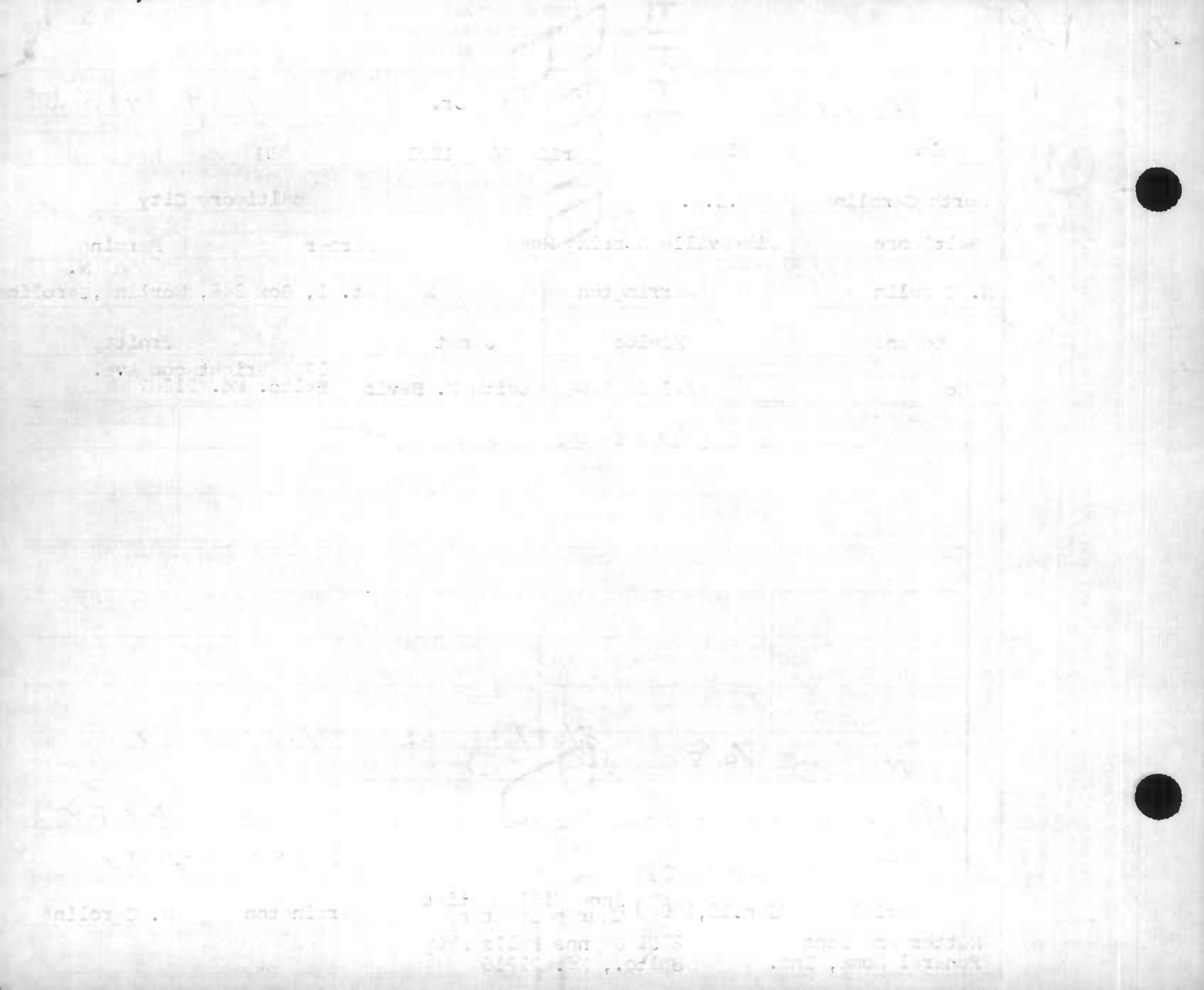
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Nathaniel Field sr.			2a. DATE OF DEATH MONTH DAY YEAR 1 9 84		2b. HOUR 5:45^{PM}
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR April 26 1893		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pikesville Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE N. Carolina 13a. COUNTY Warrington		13b. CITY OR TOWN Warrington	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE Rt. 1, Box 346, Norlina, N. Carolina 29999	
14. FATHER'S NAME FIRST MIDDLE LAST Edmond Fields		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janet Troitty			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 243 30 1464	17. INFORMANT Edith F. Davis ADDRESS 3214 Brightwood Ave. Balto. Md. 21207		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cerebral Anoxia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8/25/82 , to 1/5/84 , that (I) (we) lost saw the deceased alive on 10/5/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Harold B. B.		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-9-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD BOB		22e. ADDRESS 7220 PARK HEIGHTS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan. 13, 1984	23c. NAME OF CEMETERY OR CREMATORY Snow Hill Baptist Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Warrington N. Carolina	
24. FUNERAL DIRECTOR Nutter and Sons		25a. DATE RECEIVED BY REGISTRAR 2501 Wynns Falls Pkwy Balto., Md. 21216		25b. REGISTRAR'S SIGNATURE John J. Connelley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of Death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified also.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 6 2

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PHYLLIS E. FINCH			2a. DATE OF DEATH MONTH DAY YEAR 1 22 84			2b. HOUR 650A.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 11 1921		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
12b. KIND OF BUSINESS OR INDUSTRY -----							

13a. STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 418 Baldwin Park Place 21157	
14. FATHER'S NAME FIRST MIDDLE LAST Wilbur J. Walters					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Hull					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 217-14-1566		17. INFORMANT Mr. Donald ADDRESS E. Finch 418 Baldwin Park Place Westminster, Md. 21157					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Refractory Ventricular Tachycardia DUE TO, OR AS A CONSEQUENCE OF (b) Probable Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
---	--	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. Acute Renal Failure, Recent MI, Diabetes Mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from 12/21 , 19 83 , to 12/22 , 19 84 , that (I) (we) last saw the deceased alive on 12/21 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
---	--	--	--	--	--	--	--

22b. SIGNATURE Kamal Dial-Dottin		DEGREE MBBS		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/22/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS UNION MEMORIAL HOSPITAL			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-25-84		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Garrison Forest Baltimore Md.	
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc.				25a. DATE REC'D. BY REGISTRAR JAN 24 1984		25b. REGISTRAR'S SIGNATURE John J. Connel	
2728 Liberty Road Randallstown, Maryland 21133							

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 7 6 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CATHERINE FINNICK			2a. DATE OF DEATH MONTH DAY YEAR January 15, 1984		2b. HOUR 2:45 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7-26-1908		6. AGE (IN YEARS-LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Retired
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George W. Finnick			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minerva Lauer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-09-2890		17. INFORMANT ADDRESS Robert L. Finnick - 6118 Alta Ave - 21206	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 7991 IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 12 , 19 1984 , to JANUARY 15 , 19 84 , that (I) (we) lost saw the deceased alive on JANUARY 15 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Bruce Kinoshian				22c. DATE SIGNED 1-15-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce Kinoshian M.D.				22e. ADDRESS Church Hospital 100 North Broadway Baltimore, Maryland	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1-27-84		23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		23e. NAME OF CEMETERY OR CREMATORY			
24. FUNERAL DIRECTOR NAME ADDRESS John C. Miller Inc-6415 Belair Rd.-21206				25a. DATE REC'D. BY REGISTRAR JAN 17 1984	
				25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

NY - 100-330000

NY - 100-330000 - 100-330000 - 100-330000

OFFICE

RECEIVED



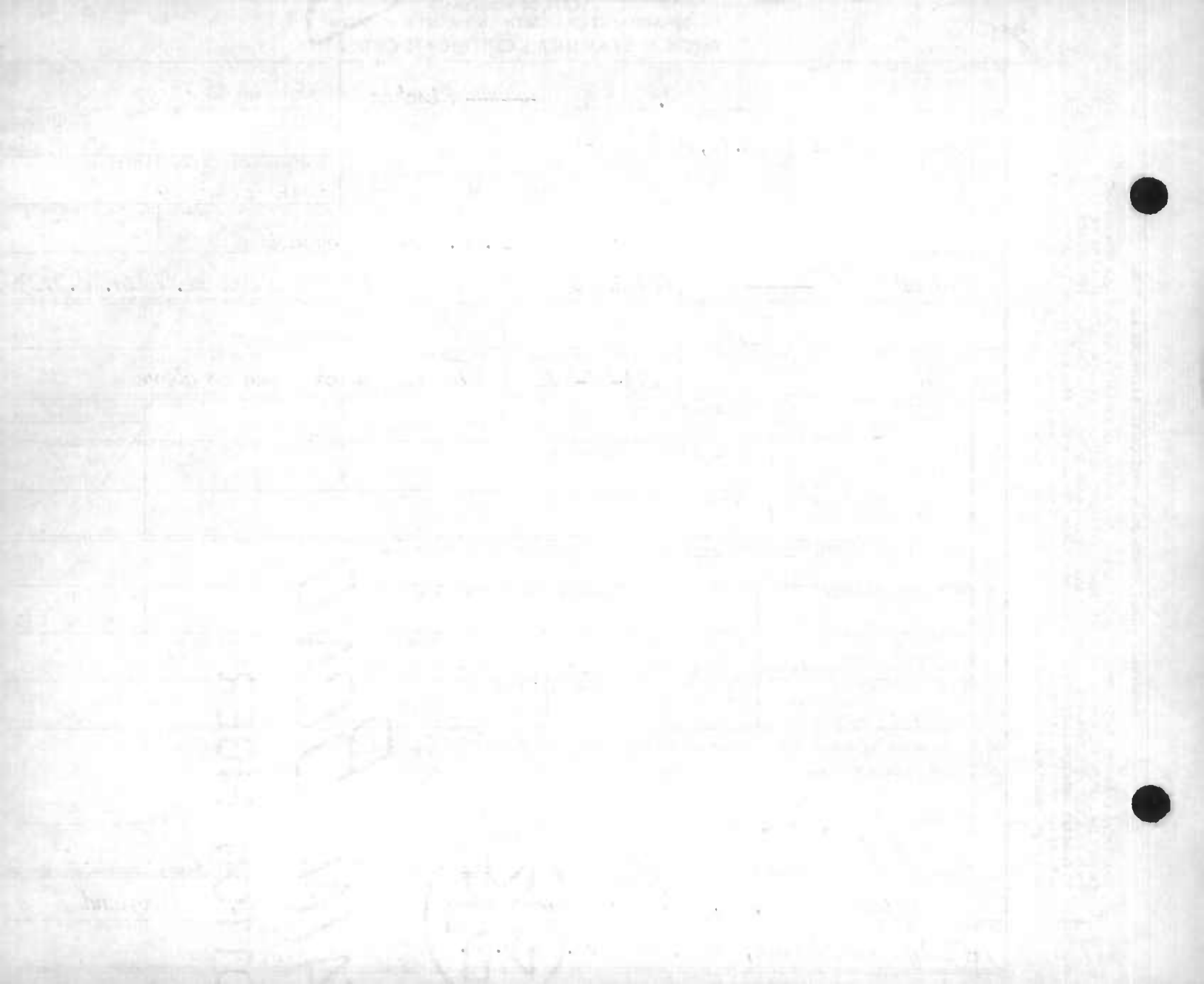
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH MATED		<input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		2b. HOUR	
ROSE		A.		FISCHER		Fischer		<input checked="" type="checkbox"/> 1 19 1984				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR	
Female	White	Jan. 12, 1904		80 YRS.						1 19 1984		1:45 a M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						MD.	
Maryland		USA				Baltimore City							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		1710 Marshall St. Balto. Md. 21230		Housewife									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		-----		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1710 Marshall St. Balto. Md. 21230					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST			
Unknown		Unknown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		213-07-6562		Vincent Church		Same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Congestive heart failure complicated by drowning 9104 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 1-19- 19 84				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject drowned in bathtub.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1710 Marshall St., Balto. Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 1-19-84					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
Ann M. Dixon, M.D.				111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION	
Burial				Jan. 23, 1984				Holy Cross Cemetery				Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
McUllly Funeral Home, 130 E. Fort Ave. Balto. Md.				JAN 20 1984									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 1 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201. OR TO BURIAL, CREMATION, OR REMOVAL.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST GEORGE W. FLOWERS JR.				1 23 84 M			
1. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YRS 10 5 33		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 60	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3030 HARFORD ROAD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 3030 Harford Road 21218		14. FATHER'S NAME FIRST MIDDLE LAST George Flowers		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara Flowers		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES	
16b. SOCIAL SECURITY NO. 368-32-2281		17. INFORMANT ADDRESS Barbara Brown 6152 Parkway Drive		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute respiratory failure and</u> <u>4960</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>C.O.P.D. with pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1-19-83</u> to <u>10-21-83</u> that (I) (we) last saw the deceased alive on <u>10-21-83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u> MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/25/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.K. RAMAIAH, MD		22e. ADDRESS VA. O.P.C. - Fed. Bldg. Balt					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/27/84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA Owings Mills,		23d. LOCATION CITY OR TOWN COUNTY STATE Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc, 1101 E North Ave.				25a. DATE REC'D. BY REGISTRAR JAN 26 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1. The first part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964. This part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964.

2. The second part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964. This part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964.

3. The third part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964. This part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964.

4. The fourth part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964. This part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964.

5. The fifth part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964. This part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964.

6. The sixth part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964. This part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964.

7. The seventh part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964. This part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964.

8. The eighth part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964. This part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964.

9. The ninth part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964. This part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964.

10. The tenth part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964. This part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964.

11. The eleventh part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964. This part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964.

12. The twelfth part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964. This part of the report is a summary of the work done during the period from 10/10/1964 to 10/10/1964.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARTHUR Gorman FORD, JR.			JANUARY 20, 1984			7:45AM	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 6 11 1923	6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md	7b. CITIZEN OF WHAT COUNTRY? USA.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Purchase Agent			12b. KIND OF BUSINESS OR INDUSTRY State	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md Carroll Finksburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3735 Old Gamber Rd		
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Gorman Ford Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flora Amanda Barnes				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW II			16b. SOCIAL SECURITY NO. 217-12-1576		17. INFORMANT ADDRESS Eleanor B Ford 3735 Old Gamber Rd		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 5713 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Alcoholic Liver Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/10/84, 19, to 1/20/84, 19, that (I) (we) lost the deceased alive on 1/20/84, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. Jameson MD				DEGREE MD		22c. DATE SIGNED 1/20/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. JAMESON				22e. ADDRESS JOHNS HOPKINS HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-23-84		23c. NAME OF CEMETERY OR CREMATORY Providence Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Gamber Carroll Md	
24. FUNERAL DIRECTOR NAME Harry W Haight				ADDRESS Sykesville		25a. DATE REC'D. BY REGISTRAR JAN 23 1984	
						25b. REGISTRAR'S SIGNATURE Sam J. Canfield	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advice obtained.

BP

CHIEF



[Faint, mostly illegible handwritten text on lined paper, possibly a letter or report.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8400967

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Mary Elizabeth Foringer</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1-29-84</i>			2b. HOUR MIN. <i>137 A.M.</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>01 23 1895</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>89</i>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>USA Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTO CITY</i> MD.				
10. CITY OR TOWN OF DEATH <i>BALTO</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>ST AGNES HOSPITAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS / ZIP CODE <i>2854 Louisiana Ave., 21227</i>			14. FATHER'S NAME FIRST MIDDLE LAST <i>Sanders</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>_____</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			16b. SOCIAL SECURITY NO. <i>215-07-5059</i>		17. INFORMANT <i>Kenneth E. Foringer</i>				ADDRESS <i>Balto., Md. 21227</i> <i>2852 Louisiana Ave.,</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction, recent, septal</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Michael Pelczar</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>1/29/84</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DR. MICHAEL PELCZAR</i>			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>2/1/1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Essex, Balto., Md.</i>			
24. FUNERAL DIRECTOR NAME <i>McCutty Funeral Homes</i>			BALTO., MD., 21225 <i>237 E. Patapsco Ave.,</i>			25a. DATE REC'D. BY REGISTRAR <i>JAN 30 1984</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

BP

A

Form

Page

01

23 1992

00

BALTO CITY

USA

ST AGNES HOSPITAL

BALTO

Address

217-7-00

THE KATHARIS BELGIAN

United States of America

1000 2122

1000 2122

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 6 8

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GEORGE N. FORNEY			2a. DATE OF DEATH MONTH DAY YEAR 1 13 84		2b. HOUR 5 P.M.
3. SEX MALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 1 4 17	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. Steel
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN GLEN BURNIE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE F FORNEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAUDE KIMBER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT ADDRESS Madeline Forney same as 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

1541 IMMEDIATE CAUSE (a). METASTATIC RECTAL CANCER

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (d), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION NONE	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1/13 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE David M. Witham	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1/13/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID MATTHEW WITHAM		22e. ADDRESS 3001 S. HANOVER ST	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 16 Jan. 84	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.	23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A. MD.
24. FUNERAL DIRECTOR NAME James S. Kirkley F.H. Glen Burnie MD.		25a. DATE REC'D BY REGISTRAR JAN 17 1984	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



92

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 7 6 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
LENORA		FOWLKES		1		20		84	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
				7 22 08		75		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
VIRGINIA		USA				BALTIMORE MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTO.		4031 BOARMAN AVE.							

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD.				BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4031 BOARMAN AVE. 21215	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST				FIRST MIDDLE LAST					
EPHRAIM				STAPLES				LUDIE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO						FLORENCE FOWLKES 4031 BOARMAN AVE.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)			
4049			
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b)			
Seizure disorder.			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
Chronic Renal failure.			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
Senile Dementia			

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		STREET		CITY OR TOWN COUNTY STATE	
				1-4-84			
22a. I certify that (I) (this hospital) attended the deceased from 1-4-84 to 1-24-84, that (I) (we) lost saw the deceased alive on 1-24-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		STAFF PHYSICIAN	
DR B. GORES H				6666 Security Blvd.		1-24-84	
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS		22e. DATE SIGNED			

23a. BURIAL, CREMATION, REMOVAL (SPRINT)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		1/24/84		ARBUTUS MEM. PK.		BALTO., MD.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
LEROY O. DYETT 4600 LIBERTY HGTS. AVE.				JAN 24 1984			
				25b. REGISTRAR'S SIGNATURE			
				Samuel Carver			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or removal.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR										2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR						2b. HOUR	
Matthew Hale Fowlkes Jr.					1-21 19 84							
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD					2d. HOUR	
Male	Black	Dec. 28 '28	55 YRS.			1-21 19 84					11:15 a. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Kentucky		USA				Baltimore City, MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Provident Hospital				Sanitary Aide			Acme Bakery			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS							
Maryland			Baltimore		3102 Garrison Blvd. 21216							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Matthew H. Fowlkes Sr.		Lena Mae Owens										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS								
Yes		Korea		216 24 8244 George W. Fowlkes 3102 Garrison Blvd.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u>												
4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												
(b) _____ DUE TO, OR AS A CONSEQUENCE OF												
(c) _____ DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED				
<i>Dennis F. Smyth M.D.</i>				M.D. Assistant				1-21-84				
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS								
Dennis F. Smyth, M.D.				111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial		1/28/84		Family Lot		Virgilina Halifax Va.						
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Nutter and Sons Funeral Home., Inc.				2501 Gwynns Falls Pkwy., Balto. Md.		JAN 27 1984 <i>John J. Connelley</i>						

BP

USA

ARMY

General Ains

General

General

1/20/54
Hester and Sons General
Home, Inc.
2501 Gwynns Falls
Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JOSEPH GEORGE FRANCE SR.				2a. DATE OF DEATH 01 18 84				2b. HOUR 12 A M			
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH 08 13 1896		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY RAILROAD			
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND		13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2607 LATONA ROAD, 21214			
14. FATHER'S NAME FIRST MIDDLE LAST JACOB --- FRANCE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHERINE --- SPORRER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 705-05-4865		17. INFORMANT CATHERINE C. FRANCE				ADDRESS 3300 BENSON AVE. APT. 229			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> <u>4280</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia, Arteriosclerosis, Chronic</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>congestive heart failure, Dehydration</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days.</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Ramon Malhotra</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-18-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. MALHOTRA				22e. ADDRESS ST. AGNES HOSP, BALT, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 01-21-84		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION CITY OR TOWN BALTIMORE CITY		STATE MARYLAND			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.				ADDRESS 21229 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR JAN 20 1984					
						REGISTRAR'S SIGNATURE <u>John J. Lander</u>					

BP

1957

1

UNITED STATES

DEPARTMENT OF

COMMERCE

ADMINISTRATIVE



OFFICE OF THE SECRETARY

WASHINGTON, D.C.

MEMORANDUM

FOR THE SECRETARY

DATE

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers, page 3 and 4 should be filed with 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

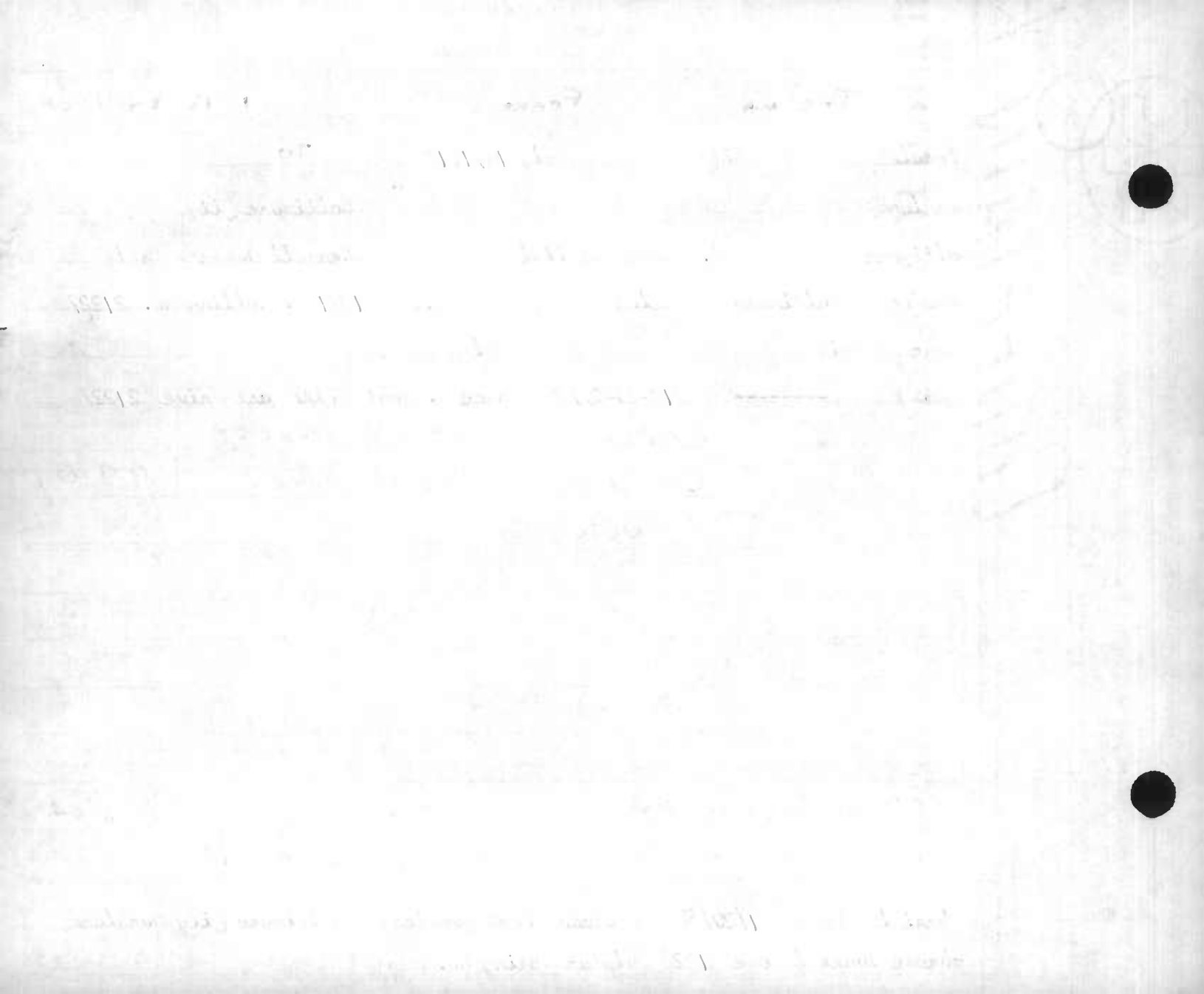
BP _____
DHMH - 16 50M 1/B1
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

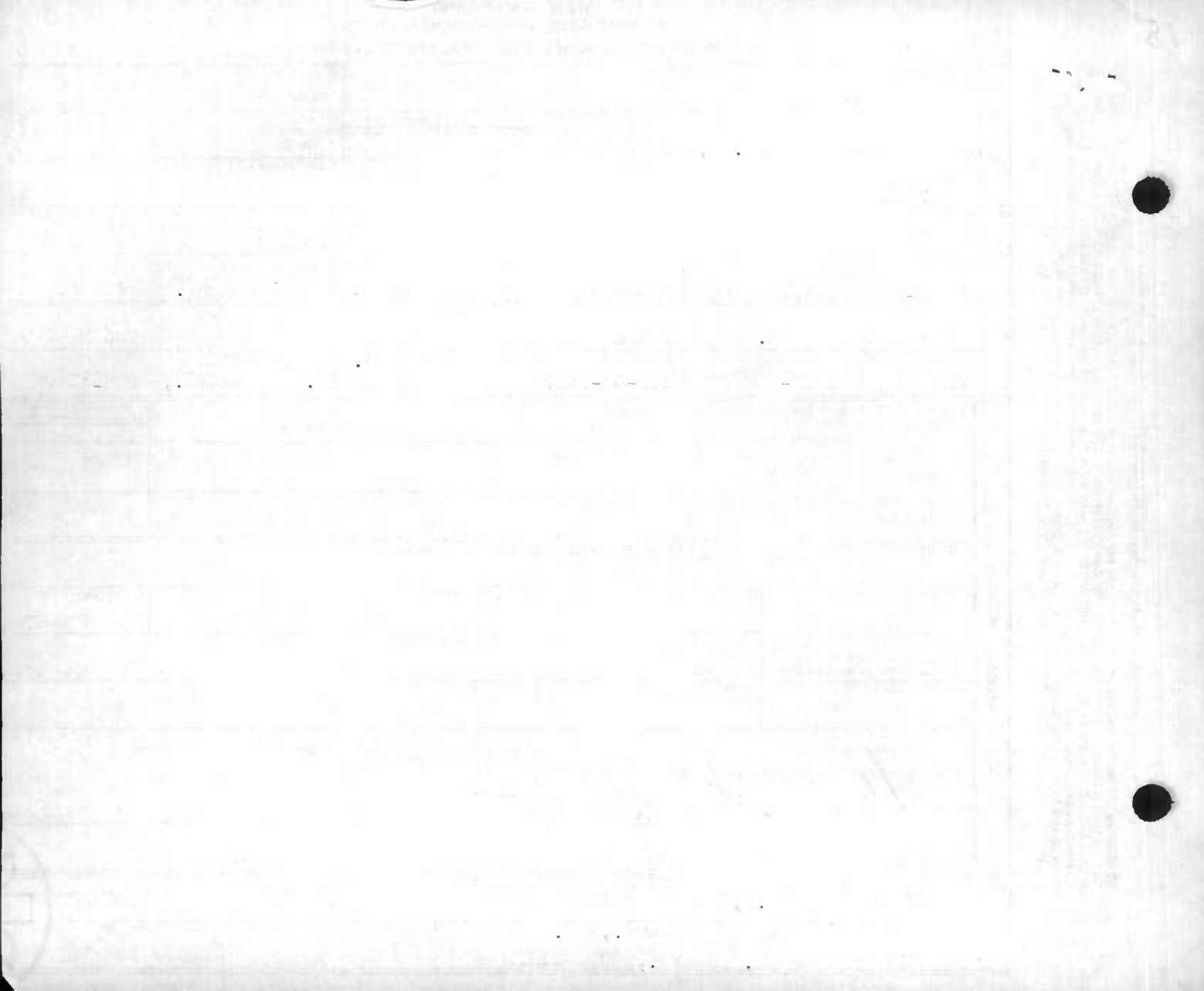
3 4 0 0 7 2

1. DECEASED NAME (TYPE OR PRINT) Thelma Francis		2a. DATE OF DEATH MONTH DAY YEAR 1 18 84		2b. HOUR 1.00 A.M.	
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR July 10, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Kennell Owner		12b. KIND OF BUSINESS OR INDUSTRY self
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Sumner Francis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma Gettus		13e. STREET ADDRESS 1601 S. Rolling Rd. 21227	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 213-20-2778		17. INFORMANT ADDRESS Bruce A. Kent 5300 East Drive 21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CHF, HTN, ABCVD, stea- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) arthritis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 97 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. MALHOTRA		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-18-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. MALHOTRA		22e. ADDRESS ST AGNES HOSP			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 1/20/84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE JAN 19 1984			
24. FUNERAL DIRECTOR NAME Ambrose Funeral Home 1328 Sulphur Spring Rd.					

MEDICAL CERTIFICATION



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Jerome Frank						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> 1/30/84 19		2b. HOUR M A			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APR. 8, 1919		6. AGE (IN YEARS) (LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YR. MONTHS DAYS XX		7. IF UNDER 24 HRS. HOURS MIN. 11:05	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PLUMBER		12b. KIND OF BUSINESS OR INDUSTRY PLUMBING			
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2405 SYLVALE RD. #21209			
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT H. FRANK						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FREDA KOGAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 217-05-5877		17. INFORMANT MRS. SOPHIE FRANK 2405 SYLVALE RD. BALTO., MD 21209							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER DATE SIGNED 1/30/84			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB. 1, 1984		23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO				23d. LOCATION BALTIMORE		COUNTY MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR FEB 8 1984		25b. REGISTRAR'S SIGNATURE <i>John J. Casper</i>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

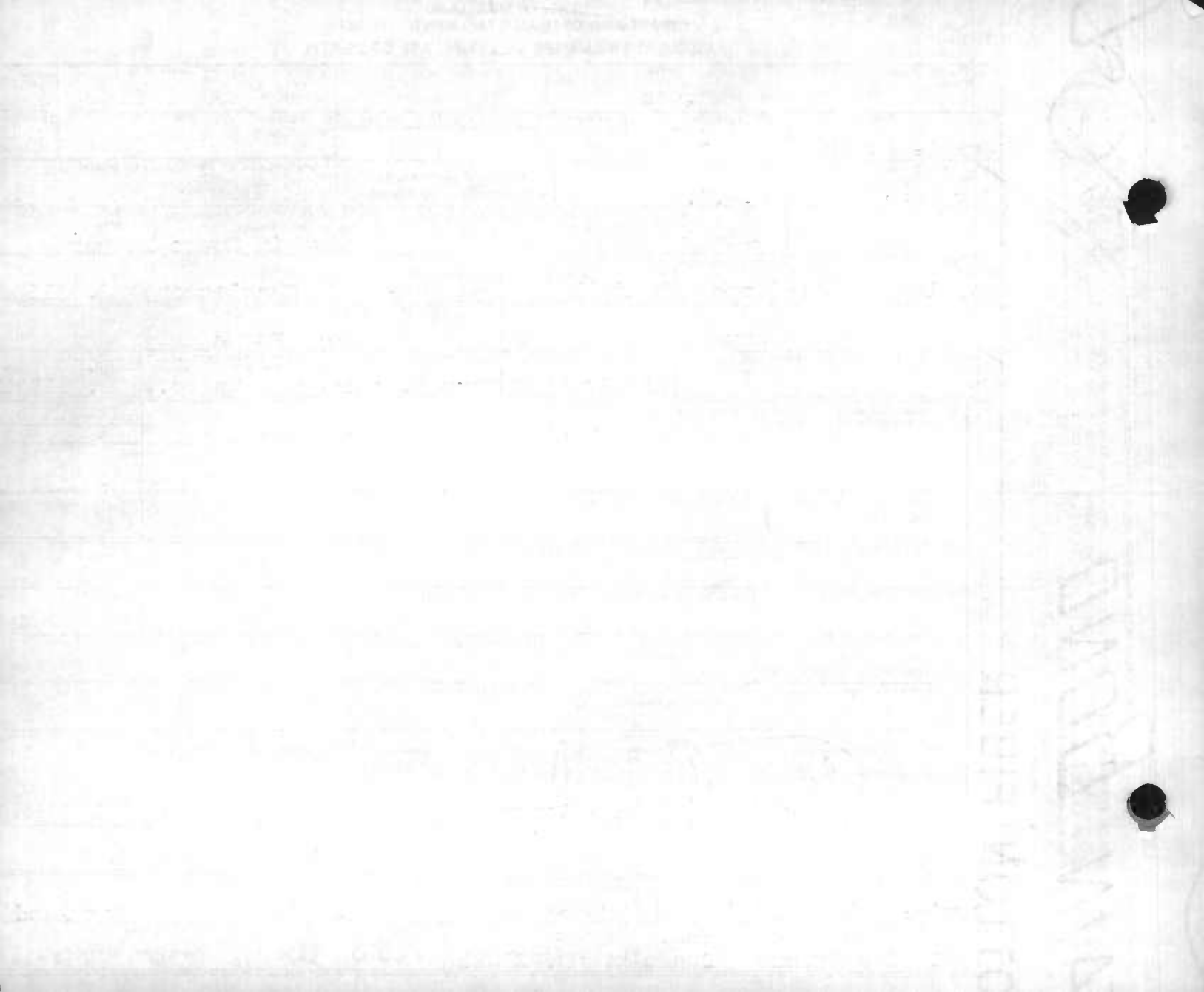
BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		4 0 0 9 7 4											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Agnes Frank										2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 31 1984		2b. HOUR M 9:15A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 9 96		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD 1 31 1984		2d. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Live in House Keeper				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7860 Charlesmont Rd. 21222			
4. FATHER'S NAME FIRST MIDDLE LAST Not Known						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Known							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-30-5979		17. INFORMANT 7860 Charlesmont Rd. Mary R. Hastmann Balto., MD. 21222							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular diseases DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that legal charge of the remains described above, held an death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE THOMAS D. SMITH, M.D.				TITLE (SPECIFY) DEPUTY CHIEF M.D.				MEDICAL EXAMINER				DATE SIGNED 1/31/84	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				111 Penn St. Balto, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2/4/1984		23c. NAME OF CEMETERY OR CREMATORY Moreland				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222						25a. DATE REC'D. BY REGISTRAR FEB 3 1984		25b. REGISTRAR'S SIGNATURE John J. Lauer					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 7 5

FOR
 1- STATE
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM L. FRANKLIN			2a. DATE OF DEATH MONTH DAY YEAR 1 17 84			2b. HOUR 745A M			
1. SEX MALE		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 14 21		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2744 Winchester St. 21216	
14. FATHER'S NAME FIRST MIDDLE LAST John Franklin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Lee					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 219-01-0618		17. INFORMANT ADDRESS Mary E. Franklin 2744 Winchester Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) adenocarcinoma of cecum 1534 DUE TO, OR AS A CONSEQUENCE OF (b) metastatic adenocarcinoma to liver, 8 months DUE TO, OR AS A CONSEQUENCE OF (c) cachexia 1 month								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Sarcoidosis, ASCVD, Dehydration									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the decedent from 1/10/84 to 1/17/84 , that (I) (we) last saw the decedent alive on 1/10/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Living J. Gottfried MD				DEGREE		22c. DATE SIGNED 1/17/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LIVING J. GOTTFRIED				22e. ADDRESS THE UNION MEMORIAL HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 1/20/84		23c. NAME OF CEMETERY OR CREMATORY Maryland Veteran Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS William C. March F/H Inc. 1101 E. North Avenue				25a. DATE REC'D. BY REGISTRAR JAN 19 1984		25b. REGISTRAR'S SIGNATURE John J. Carver			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



THE ALCOHOL BUREAU
JAN 10 1918
WASHINGTON, D.C.

INDEX

DOWN

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 7 6

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RICHARD F. FRANTA			2a. DATE OF DEATH MONTH DAY YEAR 1-25-84			2b. HOUR MIN. 5:09 PM				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 12 1930		6. AGE (IN YEARS (LAST BIRTHDAY)) 53 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KANSAS		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AUTO MECH.		12b. KIND OF BUSINESS OR INDUSTRY -		
13a. STATE MD.			13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2524 N. CALVERT ST. 21218	
14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL J. FRANTA			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY C DVORAK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. KOREA 220-32-3632		17. INFORMANT ROY FRANTA		ADDRESS 110 WILLIAMS AVE 21222				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4860 IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) pneumonia DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Head trauma (SIP Evacuation of (R) frontal hematomas X 2)										
19a. DATE OF OPERATION 1-9-84/1-16-84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Evacuation of (R) frontal he-			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR maternal			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		STATE
22a. I certify that (I) (this hospital) attended the deceased from Jan. 9 , 19 84 , to Jan. 25 , 19 84 , that (I) (we) lost saw the deceased alive on Jan. 25 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Henry Fooks, Jr. M.D.			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 1-25-84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry Fooks, Jr. M.D.			22e. ADDRESS UNION MEMORIAL HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1/28/84		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART OF MARY			23d. LOCATION CITY OR TOWN BALTO		STATE MD.
24. FUNERAL DIRECTOR NAME CONNELLY FUNERAL HOME OF DUNDALK			ADDRESS DUNDALK			25a. DATE REC'D. BY REGISTRAR FEB 1 1984		25b. REGISTRAR'S SIGNATURE John J. Lohr		

must be notified in bnc

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased was not in the hospital at the time of death, the certificate should be completed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. If the deceased was not in the hospital at the time of death, the certificate should be completed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in bnc.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARY LORAIN FRATTALI			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 12, 1984			2b. HOUR 4:02 M			
1. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 28 1924		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3405 Dunhaven Road 21222	
14. FATHER'S NAME FIRST MIDDLE LAST George R. Heymann			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary M. Steigerwald			ADDRESS 3405 Dunhaven Road Balto. MD 21222			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 219-10-0781		17. INFORMANT Ernest Frattali			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4100

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) Anterior myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

(c) Atherosclerosis

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 hr

6 days

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Atherosclerosis

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/7/84</u> , 19 <u>84</u> , to <u>January 12</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>January 12</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Daniel E. Ford, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>1/12/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DANIEL E. FORD, M.D.</u>				22e. ADDRESS <u>600 N. WOLFE ST. JOHNS HOPKINS HOSPITAL BALTIMORE, MD</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/14/84		23c. NAME OF CEMETERY OR CREMATORY Sacred Ht. of Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Balto. Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue, Dundalk, MD 21222				25a. DATE REC'D. BY REGISTRAR JAN 17 1984		25b. REGISTRAR'S SIGNATURE <u>John J. Casper</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filled in by the funeral director. Page 4 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 4 and 2 should be filed with the 24-hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

PAID ONE DOLLAR

NOV 10 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "Home", does any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1- OFFICE TO UNIVERSITY REGISTRAR Hospital 1/6/84										
CERTIFICATE OF DEATH										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST FRANK P. FRAZZANO			2a. DATE OF DEATH MONTH DAY YEAR 1/5/84		2b. HOUR 2310 M		
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 01 07 18		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.				
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY (MEMSS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lithographer		12b. KIND OF BUSINESS OR INDUSTRY Saul Litho		
13a. STATE MD					13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frank P. Frazzano					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Consiglia DelVecchio					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WWII		17. INFORMANT Address Presa A. Frazzano Wife Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pottery Embolus Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary embolus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Prolonged ill-bedrest II° to cord contusion</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Spinal</u>										
19a. DATE OF OPERATION 1/2/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Resp Arrest.				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2200 M. 12 27 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Fell in Bathroom						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from Jan 5, 19 84, to Jan 5, 19 84, that (I) (we) last saw the deceased alive on Jan 5, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE C Gilbert		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/6/83						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Gilbert		22e. ADDRESS 2301 22 S Greene St								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 9, 1984		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Mont. Md.				
24. FUNERAL DIRECTOR NAME Francis J. Collins		24a. DATE REC'D. BY REGISTRAR JAN 10 1984		24b. REGISTRAR'S SIGNATURE Francis J. Collins						
500 University Blvd., W. Silver Spring, Md.										

0122

1/2 23

1/2 23

1/2 23

1/2 23

1/2 23

1/2 23

1/2 23

1/2 23

1/2 23

1/2 23

1/2 23

1/2 23

1/2 23

1/2 23

1/2 23

1/2 23

1/2 23

1/2 23

1/2 23

1/2 23

1/2 23

1/2 23

1/2 23

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2b. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
Jack CORNELIUS		FLEMING.		01 11 84		230 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male	Black	MONTH DAY YEAR		54 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
N. Carolina	USA			BALTIMORE CITY, MD		Beth. Steel	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	SINAI		Spray Painter		Beth. Steel		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		4332 PIMLICO RD 21215			
Otis Fleming		Carrie McCurry					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)		216 20 7733		Mertina Fleming		21215	
WWII				4332 Pimlico Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA							
1809 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
HYPERCALCEMIA ANEMIA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-3-83 to 1-11-84, that (I) (we) last saw the deceased alive on 1-11-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Meenakshi Merchant				MD		1/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
MEENAKSHI MERCHANT				SINAI HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		1/17/84		Crownsville Vet.		Crownsville Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Nutter and Sons Funeral Home, Inc.		2501 Gwynns Falls Pkwy Baltimore, Md. 21216		JAN 17 1984 John J. Conner			

Water and Sons
General Home, Inc.

2501 Gwynne, Suite 100
Baltimore, Md. 21216

1/17/74 - [illegible]
[illegible]

100.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES J FRENCH			2a. DATE OF DEATH MONTH DAY YEAR 11/9/84		2b. HOUR 12:44 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 16, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Trucking	
13a. STATE Maryland		13b. COUNTY 21215		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 103 E. 33rd Street 21218		14. FATHER'S NAME FIRST MIDDLE LAST Edward French		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Lavery		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	
16b. SOCIAL SECURITY NO. W.W. 11 218-09-8696		17. INFORMANT Patricia A. Baines		ADDRESS 9115 Pulaski Hwy. 21220		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyperkalemia and Shock 0381 DUE TO, OR AS A CONSEQUENCE OF (b) Septic septicemia → septic shock and Acidosis DUE TO, OR AS A CONSEQUENCE OF (c) Acute renal failure	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Acute renal failure							
19a. DATE OF OPERATION 11/9/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11/9/84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11/9/84		22a. I certify that (I) (this hospital) attended the deceased from 11/9/84 to 11/9/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE S. Dumstha		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/9/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. DUMSTHA		22e. ADDRESS UNION MEMORIAL HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 12, '84		23c. NAME OF CEMETERY OR CREMATORY MD Veterans-GarrisonForrestBalto. Co., MD		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME William E. Johnson		ADDRESS 8521 Loch Raven Blvd.		25a. DATE REC'D. BY REGISTRAR JAN 10 1984		25b. REGISTRAR'S SIGNATURE John J. Connelley	

BP



RECEIVED

OFFICE OF THE ATTORNEY GENERAL
STATE OF NEW YORK

IN SENATE, January 10, 1911.

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
JANUARY 10, 1911.

ALBANY: J.B. LEECH, STATE PRINTER.
1911.

THE COMMISSIONERS OF THE LAND OFFICE
HONORABLE SENATOR JAMES C. HARRIS
ALBANY, N. Y.

TO THE SENATE
JANUARY 10, 1911.

ALBANY, N. Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with this report after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOWARD. DAVID FRIEDMAN.						2a. DATE OF DEATH MONTH DAY YEAR 1-16-84		2b. HOUR 3:30 PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7 27 '58		6. AGE (IN YEARS LAST BIRTHDAY) 25 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY .MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTEBELLO HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY STUDENT			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS zip----- 505 EISNER STREET 20901			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM FRIEDMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE EDNA SUKOFF							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-68-9388		17. INFORMANT ADDRESS JOEL FRIEDMAN, 4385 WHITMER DRIVE, #14 WOODBRIDGE, VIRGINIA							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 3481 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BACTEREMIA DUE TO, OR AS A CONSEQUENCE OF (c) QUADRUPLÉGIA damage 2015 CS-6 injury Brain. 2012 anoxic spell. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HOURS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from 3-28 19 77 , to 1-16 19 84 , that (I) (we) last saw the deceased alive on 1-16 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE MJD Desai				DEGREE MBBS				22c. DATE SIGNED 1-16-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAYA J. DESAI.				22e. ADDRESS MONTEBELLO HOSPITAL. 2218 2201 ARGONNE DR. BALTIMORE, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/19/1984		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH, VIRGINIA					
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W. WASHINGTON, D. C.						25a. DATE REC'D. BY REGISTRAR JAN 23 1984					

Handwritten: 1880

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nathan Friedman			2a. DATE KNOWN OF DEATH ESTI-MATED MONTH DAY YEAR 1 3 19 84			2b. HOUR M 6:55A		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR OCT. 14, 1915	6. AGE (IN YEARS) (LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 3 19 84		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELECTRONICS		12b. KIND OF BUSINESS OR INDUSTRY EMC CORP.
13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 5712 HIGHGATE DR. 21215		
14. FATHER'S NAME FIRST MIDDLE LAST ISADORE FRIEDMAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH KATZ					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 212-10-8862		17. INFORMANT MRS. ETHEL M. FRIEDMAN 5712 HIGHGATE DR. BALTO., MD 21215			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE Thomas D. Smith, M.D.			TITLE (SPECIFY) Deputy Chief			DATE SIGNED 1/3/84		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St. Balto., MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JAN. 4, 1984		23c. NAME OF CEMETERY OR CREMATORY MIKRO KODESH-BETH ISRAEL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.			ADDRESS 6010 REISTERSTOWN RD. BALTO. MD 21215			25a. DATE REC'D. BY REGISTRAR JAN 5 1984		
						REGISTRAR'S SIGNATURE John J. Conner		

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

RECEIVED
MAIL ROOM
JAN 10 1964

RECEIVED
JAN 10 1964



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

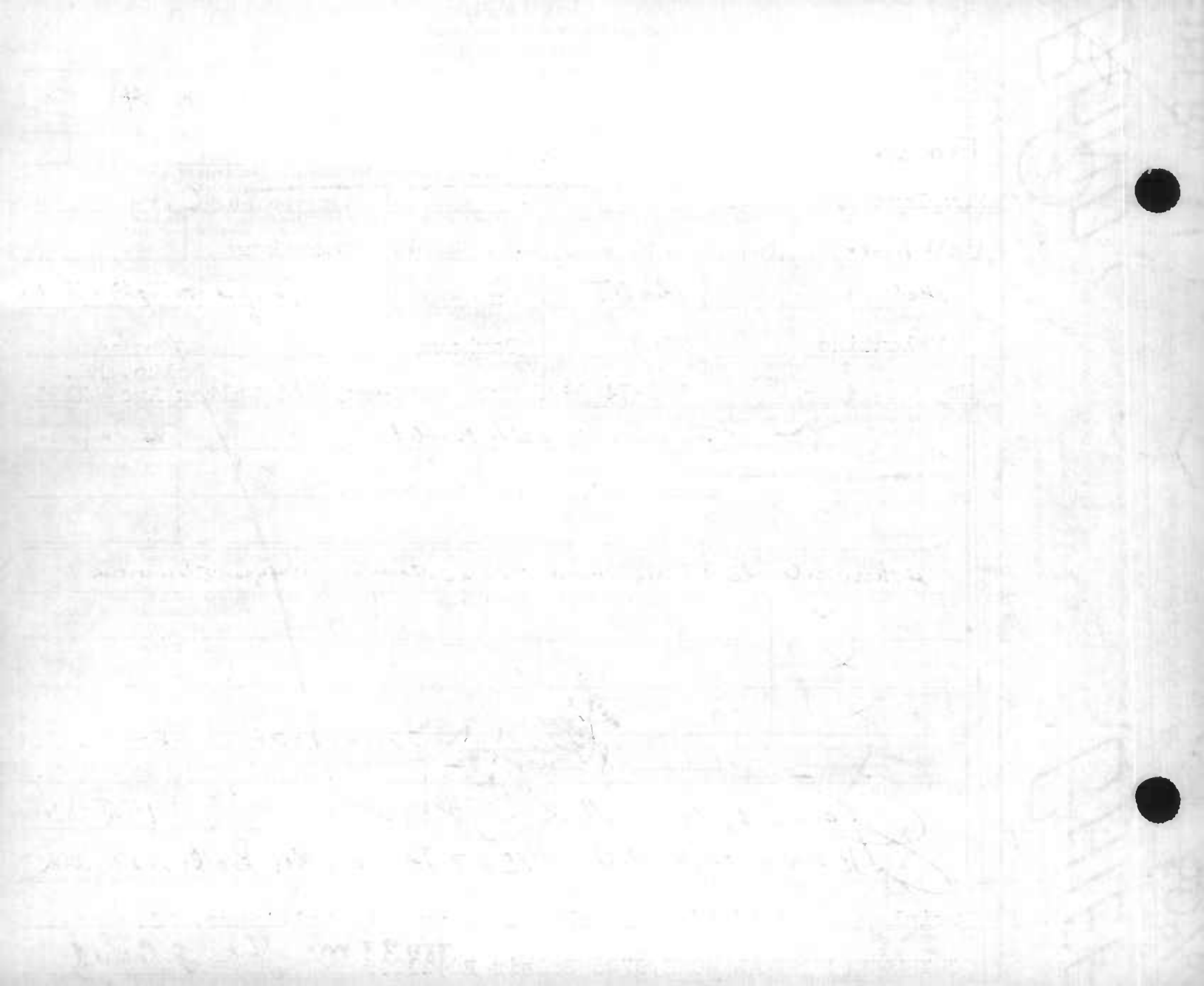
8 4 0 0 9 8 3

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		2b. HOUR	
Edna Friesner		1 28 84		9 40 A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	88 YRS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA		Baltimore City MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Meridian Nursing Center - Hamilton		Homemaker		-
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
Md		Balto		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		220-74-9995	
Valentine King		Barbara Ehrman		Ruth Metzger, 4044 Walter Ave, 21236	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		17b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		220-74-9995		Balto, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia - atelectasis.</i> 4860 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Atherosclerosis, Coronary Vascular Disease, Senile, generalized Edema</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 days.
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
X				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>JUNE 19 77</i> to <i>1-28 84</i> , that (I) (we) last saw the deceased alive on <i>1-28 84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>John C. Hyle</i>		22c. DATE SIGNED <i>1-28-84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE RECD. BY REGISTRAR	
JOHN C. Hyle MD		7527 Belair Rd Balto 21236 Md		John J. Canfield	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		1/31/84		Holy Redeemer	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. NAME OF FUNERAL DIRECTOR		23f. ADDRESS	
Baltimore, Md.		SCHIMUNEK FUNERAL HOME, 9705 Belair Rd		JAN 31 1984	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or medical examiner's assistant should be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transfer permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 7 8 4

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>C-ENTRANCE FRINDMAN FRINDMAN</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1 26 84</i>			2b. HOUR <i>9 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5 4 12</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>71</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>unknown</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>CITY</i>	
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO IN-SUCH FACILITY, GIVE STREET ADDRESS) <i>BON SECOURS HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired Nurse</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i> 13b. COUNTY <i>BALTO</i> 13c. CITY OR TOWN <i>BALTO</i>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS APT. CODE <i>3513 Poplar ST</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>UNK unknown</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>UNK</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>213-14-9741</i>		17. INFORMANT NAME ADDRESS <i>Shelia Jones 2313 Poplar St Baltimore 21216</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *1440 TRANSITION*

1629

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *BOWEL OBSTRUCTION*

DUE TO, OR AS A CONSEQUENCE OF

(c) *METASTATIC LUNG CANCER*

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from <i>1/26</i> , 19 <i>83</i> , to <i>1/26</i> , 19 <i>83</i> , that (b) (I) lost saw the deceased alive on <i>1/26</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John Shoun</i>				DEGREE		22c. DATE SIGNED <i>1/26/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DAN CHALBOS</i>				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>1/30/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mount Zion</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore MD</i>	
24. FUNERAL DIRECTOR <i>McCremon</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 27 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>	

1860

1860

1860

1860

1860

1860

1860

1860

1860

1860

1860

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DOROTHY L. FRITZ			2a. DATE OF DEATH MONTH 1 / DAY 3 / YEAR 84		2b. HOUR 6 P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH November DAY 5 YEAR 1911		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dietetic Sup.		12b. KIND OF BUSINESS OR INDUSTRY Union Memorial
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Harry MIDDLE L. LAST Small		15. MOTHER'S MAIDEN NAME FIRST Ethel MIDDLE E. LAST Hunt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-34-7864		17. INFORMANT James T. Fritz -3307 Whitesworth Rd.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Hepatic encephalopathy**
5713
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) **Alcoholic liver disease**
DUE TO, OR AS A CONSEQUENCE OF
(c) **Alcohol abuse**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

5 days**years**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **no**

MEDICAL CERTIFICATION

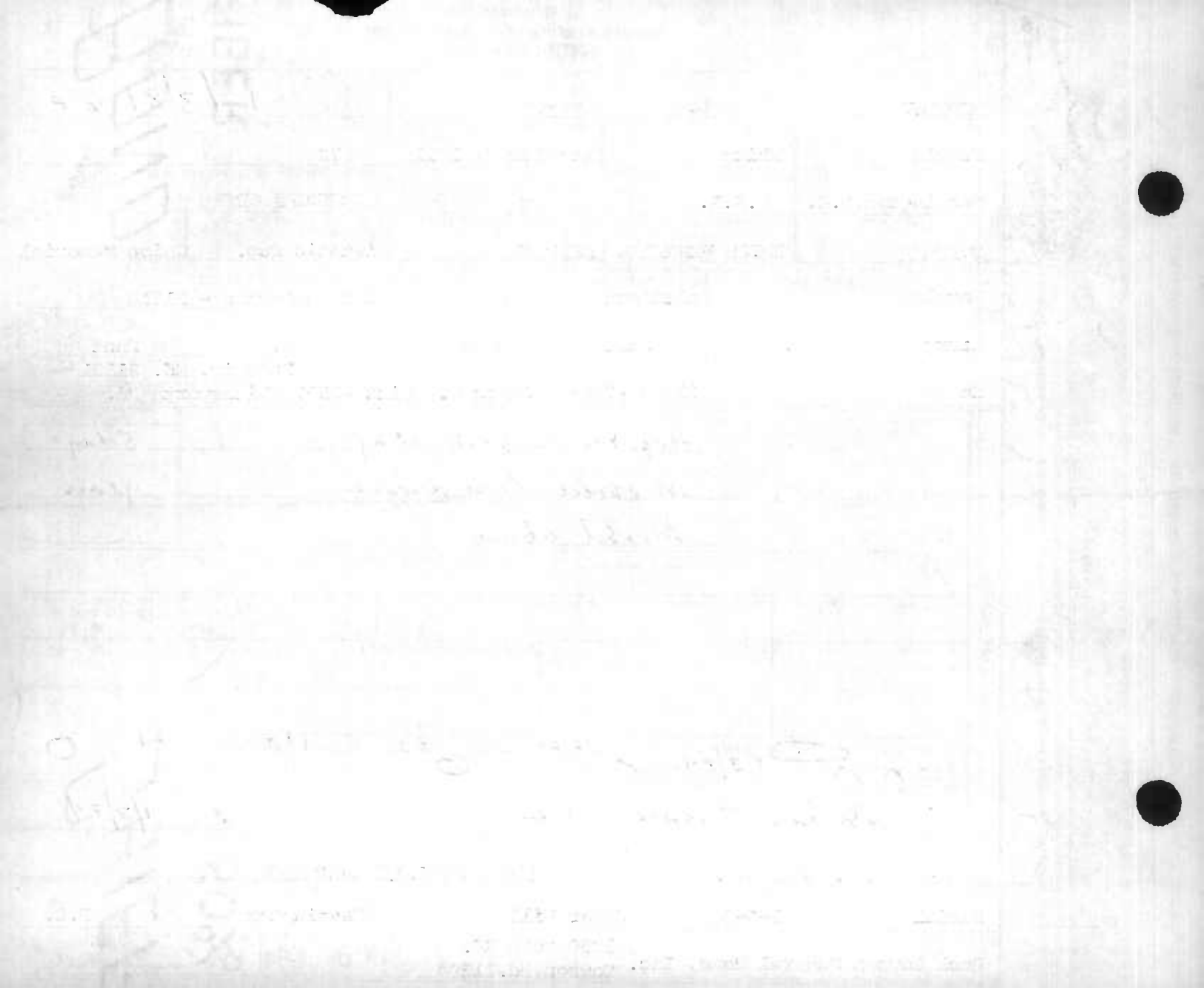
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/29 19 83 , to 1/3 19 84 , that (I) (we) lost saw the deceased alive on 1/3/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Barbara M Rock M.D.	DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/3/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARBARA M. ROCK MD.		22e. ADDRESS UNION MEMORIAL HOSPITAL	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-6-84	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	23d. LOCATION CITY OR TOWN Washington COUNTY D.C. STATE D.C.
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. ADDRESS 1050 York Rd. Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR JAN 5 1984 25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



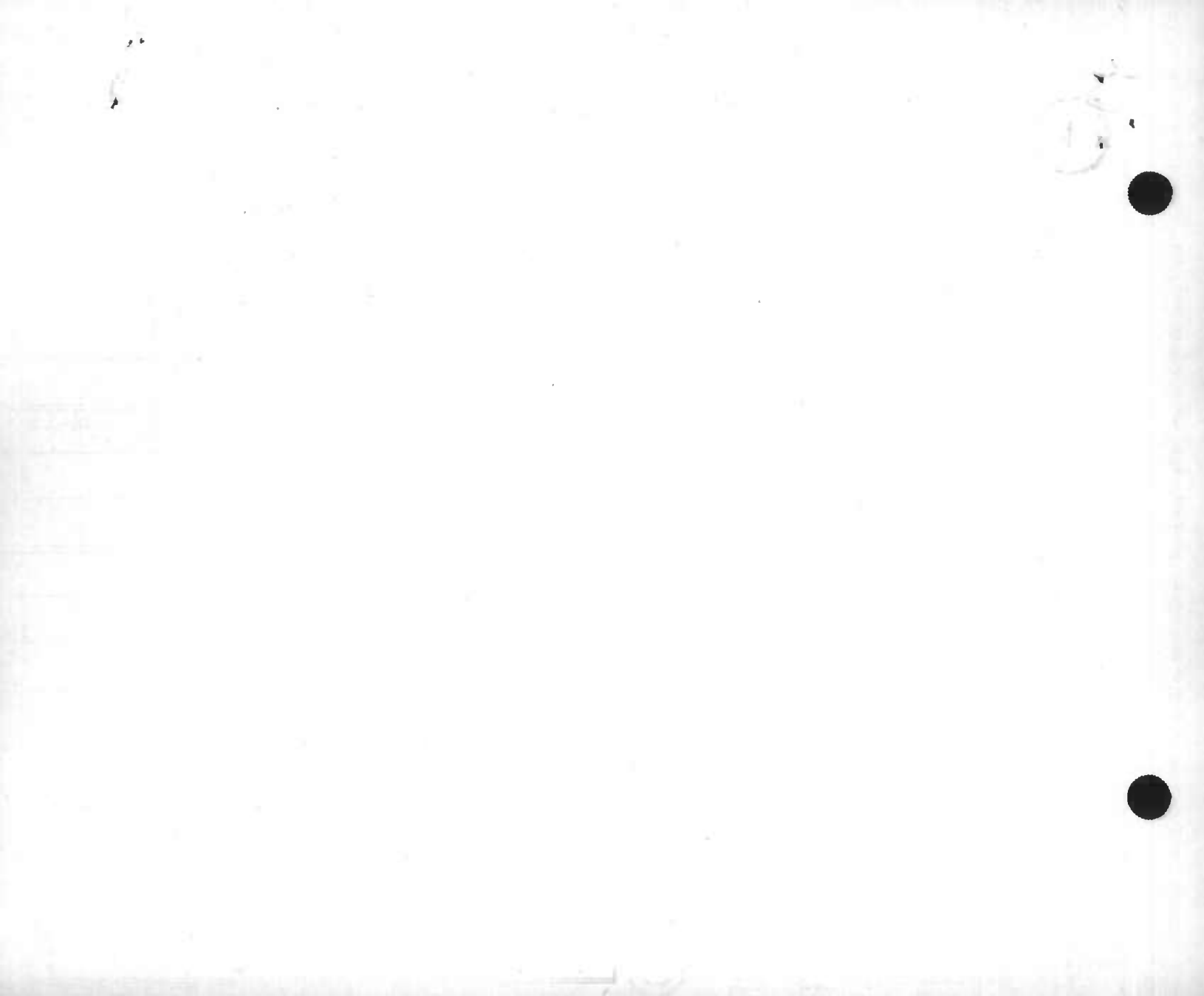
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) LILLIAN F. FUNDERBURK				2a. DATE OF DEATH MONTH DAY YEAR 1/9/84			
3. SEX F				4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6/24/19	
6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		8. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MT. SINAI NSG. HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SPRINT		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY BALT.		13c. CITY OR TOWN		14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
15. FATHER'S NAME FIRST MIDDLE LAST Edward S. Warfield		16. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		17. STREET ADDRESS 21223		18. BOX OR PO BOX Box 171	
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		19b. SOCIAL SECURITY NO. 219-07-2825		20. INFORMANT Mr. Max Funderburk		21. ADDRESS Bedford, Mass. 01730	
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPSIS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CWA							
23a. DATE OF OPERATION		23b. CONDITION FOR WHICH OPERATION WAS PERFORMED		24a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		24b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		25b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
26a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		26b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		26c. LOCATION STREET CITY OR TOWN COUNTY STATE			
27a. I certify that (I) (this hospital) attended the deceased from 10-21 , 19 83 , to 1-9 , 19 84 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1-9 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
27b. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED 1-10-84	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Lebow				27e. ADDRESS 3640 FORDS LANE BALTO 21245			
28a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		28b. DATE 1/9/84		28c. NAME OF CEMETERY OR CREMATORY		28d. LOCATION CITY OR TOWN COUNTY STATE	
29. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		30. DATE RECEIVED BY REGISTRAR JAN 20 1984	
				31. REGISTRAR'S SIGNATURE [Signature]			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 8 7

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLARA AGNES FURLONG			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 18, 1984			2b. HOUR A M 6:15			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 21, 1889		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 94		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6234 The Alameda				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson		12b. KIND OF BUSINESS OR INDUSTRY Shoe	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6234 The Alameda 21239			
14. FATHER'S NAME FIRST MIDDLE LAST William F. Brown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor Callahan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 218-14-7200		17. INFORMANT ADDRESS Mrs. Clara E. Hunt Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 Myocardial Infarction IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 7/8/75 , 19____, to 4/17 , 19 84 , that (1) (we) lost saw the deceased alive on 4/12/84 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) see the body after death.									
22b. SIGNATURE W. M. Smith			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/18/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. Meredith Smith, M.D.			22e. ADDRESS 1900 E. Northern Pkwy. Balto., Md. 21239						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 21, 1984		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto. Co., Md.		
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212			ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR JAN 25 1984		25b. REGISTRAR'S SIGNATURE John J. Connel		

35
00
25
00
1

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

11-10

11-10, 11-10

11-10, 11-10

11-10

11-10

11-10, 11-10

11-10

11-10, 11-10

11-10, 11-10

11-10, 11-10

11-10, 11-10

11-10, 11-10

11-10, 11-10

11-10, 11-10

11-10, 11-10

11-10, 11-10

11-10, 11-10

11-10

11-10, 11-10

11-10, 11-10

11-10, 11-10

11-10, 11-10

11-10

11-10, 11-10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

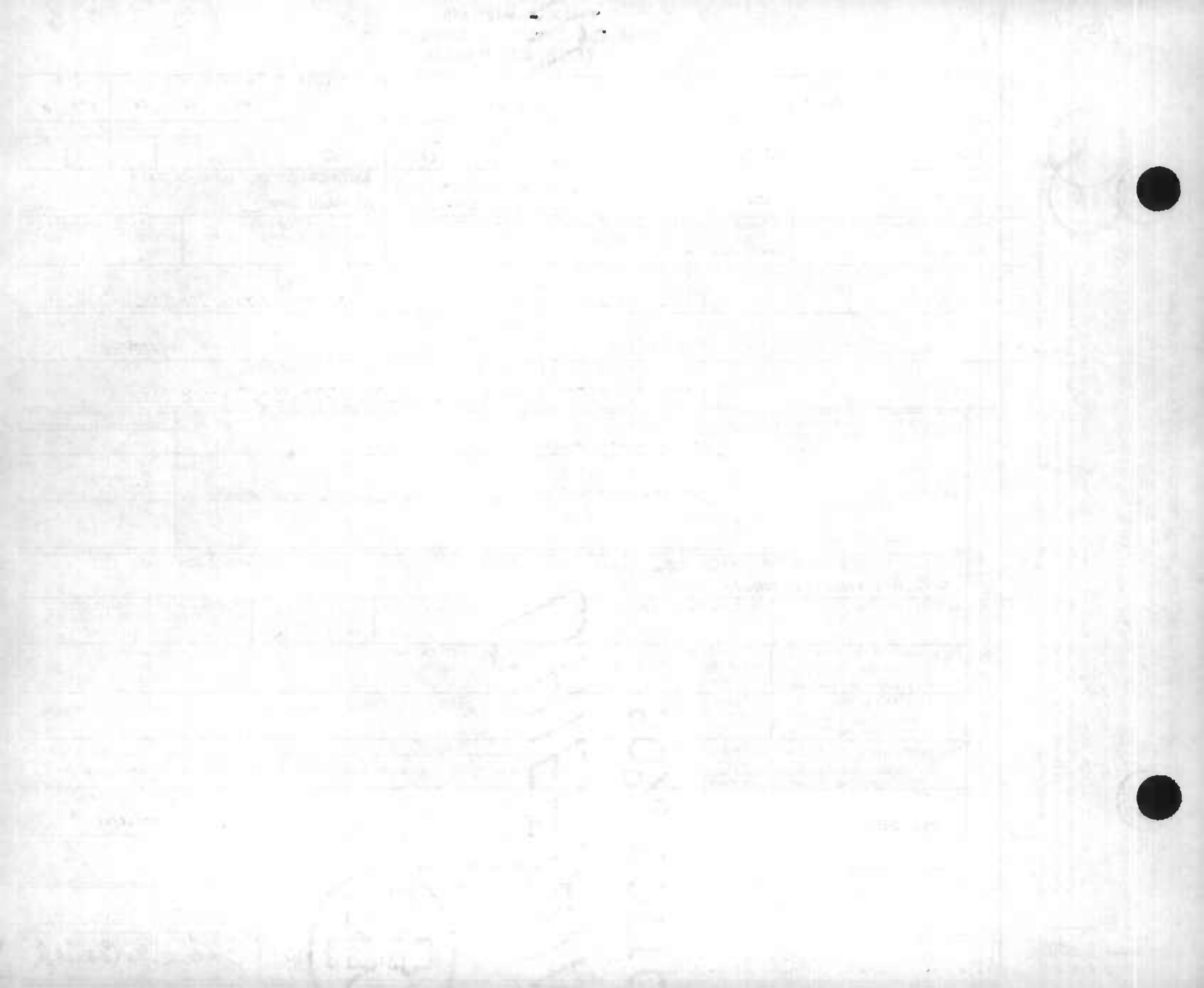
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST FREDRICK	MIDDLE	LAST FURLOW	2b. DATE OF DEATH		MONTH 01	DAY 26	YEAR 84	2b. HOUR 801 P M	
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 731 Lyndhurst Avenue 21229			
14. FATHER'S NAME		FIRST Frederick		MIDDLE		LAST Furlow		15. MOTHER'S MAIDEN NAME		FIRST Zeddie		LAST Carter	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-20-8952		17. INFORMANT Katie M. Furlow		ADDRESS 731 Lyndhurst Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> <u>1620</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ENDOTRACHEAL CARCINOMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <u>ASVD, HTN, rheumatoid arthritis.</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Steven Baurs</u>						DEGREE M.D.				22c. DATE SIGNED 01/26/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN BAURS, M.D.						22e. ADDRESS SINAI HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/30/84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forrest VA		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Maryland							
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue						25a. DATE REC'D. BY REGISTRAR JAN 30 1984		25b. REGISTRAR'S SIGNATURE <u>John J. Conish</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MICHAEL W. FURMAN			2a. DATE OF DEATH MONTH DAY YEAR JAN. 31 84			2b. HOUR 6:45pm					
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 3 - 10 - 27		6. AGE (IN YEARS LAST BIRTHDAY) 56		7. UNDER 1 YEAR MONTHS DAYS YRS.		8. UNDER 24 HRS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN. HOSP.				12a. USUAL OCCUPATION (IF OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Retiree			
13a. STATE MD		13b. COUNTY Harford		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1303 Hulse St. Balt. Md 21230			
14. FATHER'S NAME FIRST MIDDLE LAST Michael Furman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Therrie Mikos							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE DATE) W.H. Perry 214-20-4305		17. INFORMANT NAME Michael E. Furman		17. ADDRESS 1628 E. Tol		Age 21330			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 0389 IMMEDIATE CAUSE (a) Sepsis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a ADENOCARCINOMA OF PROSTATE											
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR NA		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Florante Richard Y. Mancad MD				DEGREE MD				22c. DATE SIGNED 1/31/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FLORANTE RICHARD MANCAD				22e. ADDRESS SOUTH BALTIMORE GEN. HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE 2/1/84		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Harford MD					
24. FUNERAL DIRECTOR NAME CHARLES STEVENS FUNERAL HOME INC.		ADDRESS 150 E. FORT AVE		25a. DATE REC'D. BY REGISTRAR FEB 2 1984		25b. REGISTRAR'S SIGNATURE John J. Carver					

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

18 12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) JAMES F. GALLAGHER, SR.					2a. DATE OF DEATH MONTH 1 DAY 4 YEAR 84				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH MAY DAY 22 YEAR 1914		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		2b. HOUR 12:40 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SHEET METAL WORKER		12b. KIND OF BUSINESS OR INDUSTRY INSTRUMENT CO	
13a. STATE MD.		13b. COUNTY -		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS APT. D 5756 CEDONIA AVE.	
14. FATHER'S NAME FIRST JOHN MIDDLE GALLAGHER LAST GALLAGHER					15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE McGROARTY LAST McGROARTY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES (IF YES, GIVE WAR OR DATES) WW II					16b. SOCIAL SECURITY NO. 189-03-2922		17. INFORMANT ADDRESS MARY GALLAGHER (WIFE) SAME ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes 90 minutes									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONTRIBUTING TO DEATH									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (1) (this hospital) attended the deceased from 1-4 19 84 to 1-4 19 84 , that (1) (we) lost saw the deceased alive on 1-4 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22a. SIGNATURE Jeffrey R. Kirsch DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-4-84	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey R. Kirsch						22e. ADDRESS Johns Hopkins Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/7/84		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL HOME NAME Schumnek Funeral Home, Inc. ADDRESS 9705 Belair Rd., Balto. Md. 21236						25a. DATE REC'D. BY REGISTRAR JAN 8 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

BP

30-00
column 10

Carroll Street
Bridgeway Street

X

11/11/11

2000 C 10

10-81

10-81

10-81

10-81

10-81

10-81

10-81

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 00991	
1. DECEASED NAME (TYPE OR PRINT) Lonnie Edward Gallagher										2a. DATE OF DEATH 1-12-84	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 5 18 19 65		6. AGE (IN YEARS) 65		7. DATE OF DEATH 1-13-84		2b. HOUR 10:24	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14 E. Madison St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Railroadman		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES		13e. STREET ADDRESS 14 E. Madison Street, 21202	
14. FATHER'S NAME Patrick H. Gallagher						15. MOTHER'S MAIDEN NAME Lilly Champion					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. WW II 229-09-6811		17. INFORMANT ADDRESS 23851 Wright Funeral Home 206 West 4th Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Margareta A. Korell						TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 1-13-84		
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.						ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2/3/84		23c. NAME OF CEMETERY OR CREMATORY South Hampton Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Franklin South Hampton VA	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.						ADDRESS 21229 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR FEB 3 1984		25b. REGISTRAR'S SIGNATURE Jan J. Carver	

STATION OF THE ...
...
...

10
10
10



...
...
...

...
...
...

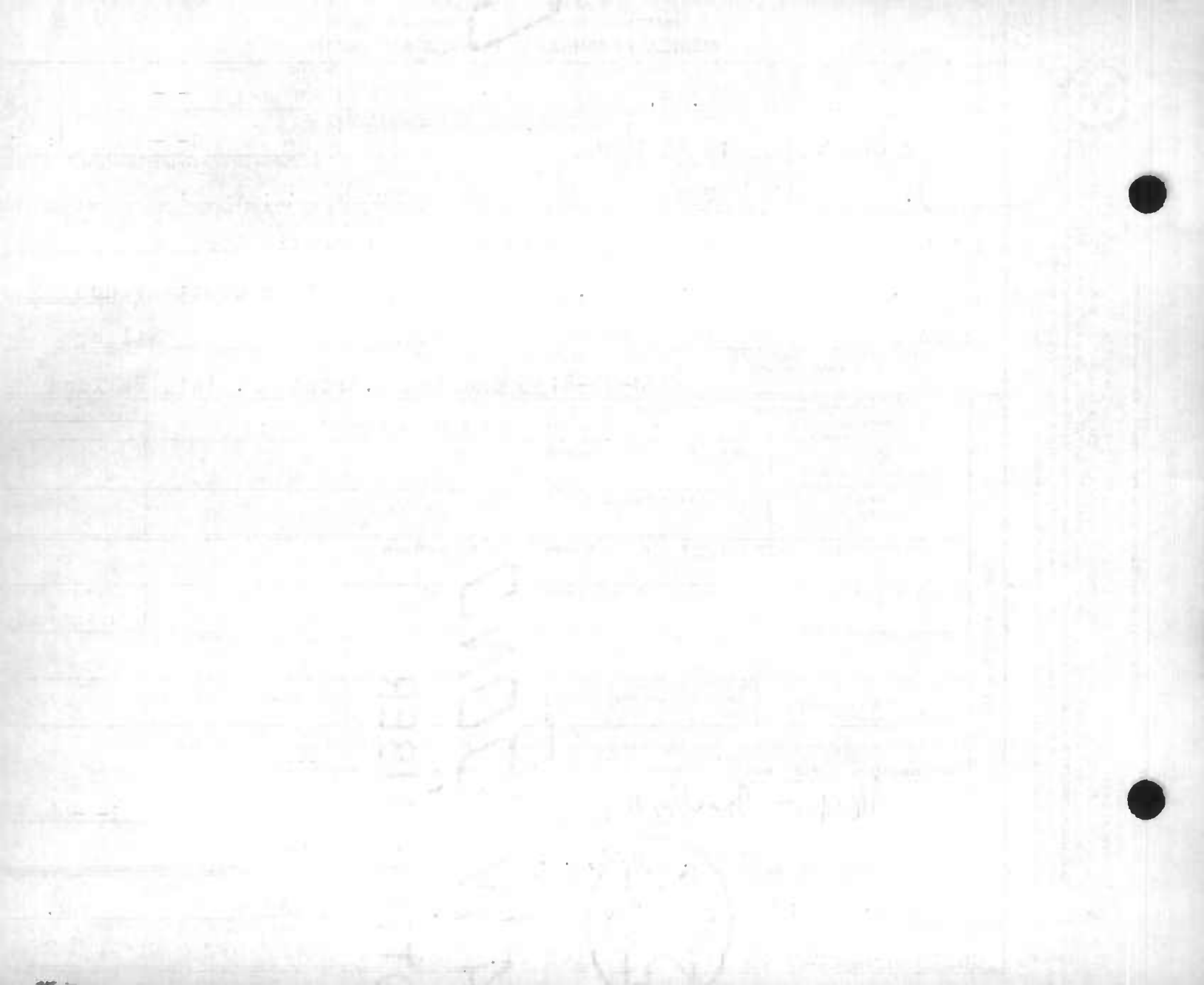
BP

DHMM - 17
(VR A15 ME (1))
20M 4/B2

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) KATIE L. M. GAMBRELL										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 1-5-84	
1. SEX F	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 9 19 1899	6. AGE (IN YEARS) LAST BIRTHDAY 84 YRS.	IF UNDER 1 YR. MONTHS DAYS 19	IF UNDER 24 HRS. HOURS MIN. 4:05P	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-5-84	2b. HOUR 4:05P				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6011 Prescott Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic Work		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6011 Prescott Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Turner Lee				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie Miller							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-07-8135		17. INFORMANT ADDRESS Charles L. Brown Sr. 1419 Bellona Av.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 1-6-84			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/9/84				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.			
23d. LOCATION CITY OR TOWN Brooklyn				COUNTY Md.				STATE			
24. FUNERAL DIRECTOR NAME Chatman-Harris FH				ADDRESS 1701 McCulloh St.				25a. DATE REC'D. BY REGISTRAR JAN 9 1984		25b. REGISTRAR'S SIGNATURE John J. Caw	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) BETTY J GARDNER			2a. DATE OF DEATH MONTH DAY YEAR 1-11-84			2b. HOUR 12:50 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1-11-26		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hagerstown, MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife		12b. KIND OF BUSINESS OR INDUSTRY at Home	
13a. STATE MD		13b. COUNTY ✓		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 32 S. Fulton Avenue 11223	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Mae Woolford					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ✓		17. INFORMANT Mrs Paula Spokes 32 S. Fulton Ave		ADDRESS 11223			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY THROMBOSIS, CIRCUMFLEX DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1) OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from JAN. 10 , 19 84 , to JAN. 11 , 19 84 , that (I) (we) last saw the deceased alive on JAN. 11 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Michael E. Pelczar				DEGREE MD				22c. DATE SIGNED 1/12/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael E. Pelczar, M.D.				22e. ADDRESS St. Agnes Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/14/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City MD.			
24. FUNERAL DIRECTOR NAME John Cowan, Son Inc.				ADDRESS 901 21223 Hollins St		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN. 17 1984 John J. Carver			

MEDICAL CERTIFICATION

30

11 JUL

10

11 JUL

11

11 JUL

Handwritten text at the bottom of the page, possibly a signature or date.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84 00994

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HERBERT GARDNER			2a. DATE OF DEATH MONTH DAY YEAR 1-20-84			2b. HOUR 12 30 A	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 2 09		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (IF OF WORK FOR MOST OF WORKING LIFE) Mail Handler	
12b. KIND OF BUSINESS OR INDUSTRY Post Office							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md. 13c. CITY OR TOWN Balto. 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 4300 Dewey Ave. 21211							
14. FATHER'S NAME FIRST MIDDLE LAST Farmer Ross Gardner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Evelyn Whiting			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-24-2216		17. INFORMANT Mrs. Lucinda Gardner (Same as #13.)			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHIMMEDIATE CAUSE (a) CAEPPAC ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last(b) DIABETES MELLITUS

DUE TO, OR AS A CONSEQUENCE OF

(c) END STAGE CHRONIC DISEASE - CIRCULATORY

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Scott Gersh</u>				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-20-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Scott Gersh				22e. ADDRESS 201 E. UNIVERSITY PARKWAY BALTO MD. 21218			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 1/20/84		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JAN 23 1984	
						25b. REGISTRAR'S SIGNATURE <u>Samuel...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1000

8

13-05-1



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 21, the medical examiner's signature is required.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH			2b. HOUR
NETTIE		GARRETT			01 11 84			4:10P
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
F	NEGRO	3 4 1887		96		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
N.C.	U.S.A.			BALTIMORE CITY MD.				
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE		THE JOHNS HOPKINS HOSPITAL		Labor				
13a. STATE		13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS / ZIP CODE				
M.D.		BAITU.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2518 E. EAGER ST. #21205				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
Miles		SARAH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO		214-225891		Mrs. SARAH Thompson 2518 E. EAGER ST. #21205				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY:								
1519 IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) <u>adenocarcinoma of stomach</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
<u>anemia; GI. bleeding</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>1/5</u> , 19 <u>84</u> , to <u>1/11</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>1/10</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		22c. DATE SIGNED				
<u>Mindy Shapiro MD</u>				<u>1/11/84</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
Shapiro		The Johns Hopkins Hosp						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		1-11-84		BAITU. NAT. Cem.		BAITU. MD.		
24. FUNERAL DIRECTOR		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE				
Bettis Funeral Home 1129 N. Caroline St.		JAN 13 1984		John J. Carver				

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 0 9 9 6

FOR
1- STATE
REGISTRAR

REG. NO.

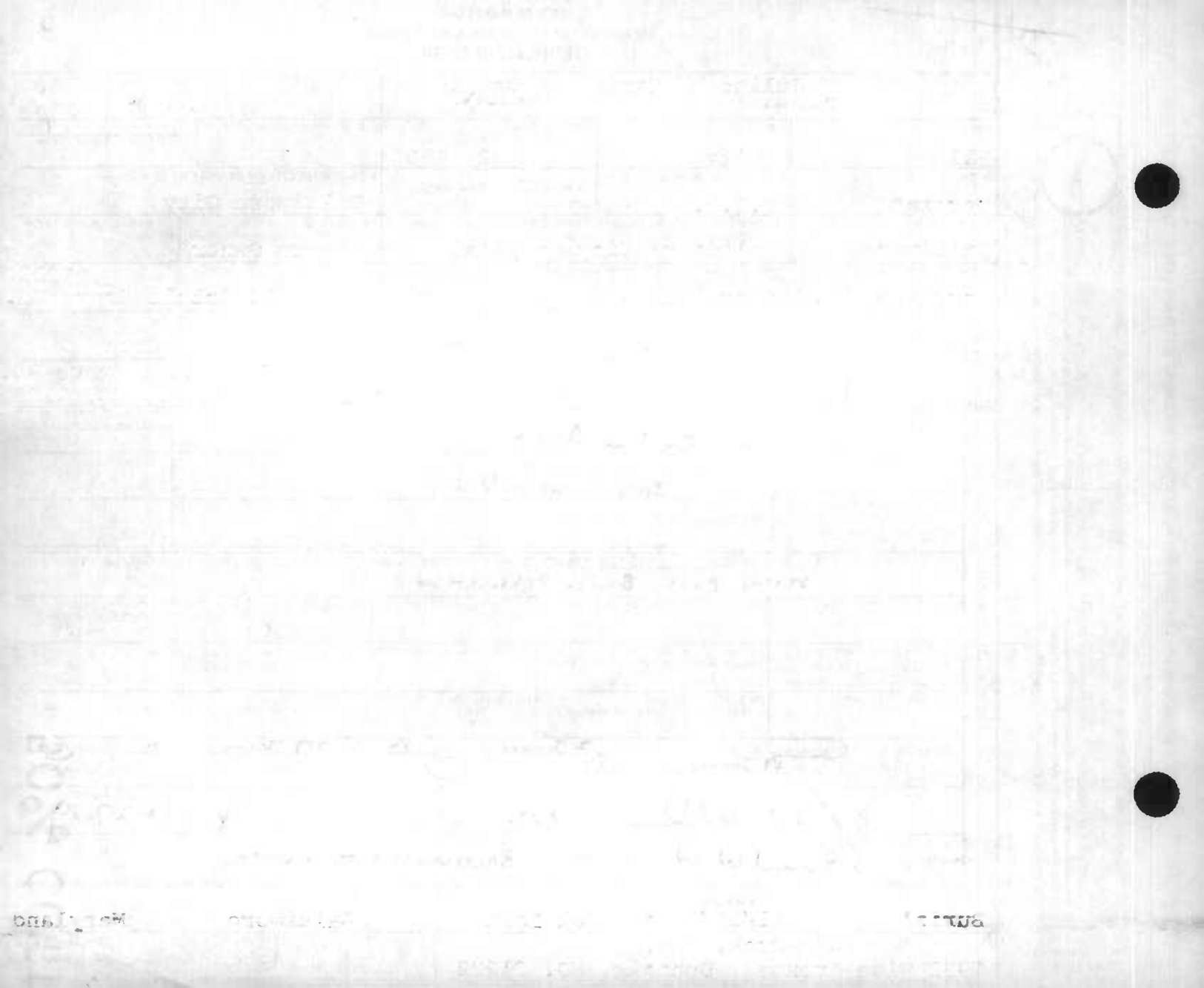
1. DECEASED NAME (TYPE OR PRINT) FIRST Julius MIDDLE Marion LAST Gawlik Julius GAWLIK		2a. DATE OF DEATH MONTH 1 DAY 27 YEAR 84 1050 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 2 DAY 2 YEAR 1908	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tavern Owner	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST Cazmier MIDDLE Gawlik LAST Gawlik		15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE Koch LAST Koch	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217-18-6958	
17. INFORMANT Helen P. Gawlik		7402 Old Battle Grove Rd. Balto., MD. 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Ischemic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: STATU POST BOWEL PERFORATION			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2 January 1984 to 27 January 1984 , that (I) (we) last saw the deceased alive on 27 January 1984 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE R. W. Wilson, MD		22c. DATE SIGNED 1-27-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond W. Wilson, MD		22e. ADDRESS BALTIMORE CITY HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/31/1984	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222		25a. DATE REC'D. BY REGISTRAR JAN 31 1984 25b. REGISTRAR'S SIGNATURE John J. Ganiel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2, and 4 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 00997	
1. DECEASED NAME (TYPE OR PRINT) Angela Marie Geckle						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/>		MONTH DAY YEAR 1 1 19 84		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 19, 1966		6. AGE (IN YEARS LAST BIRTHDAY) 17 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student			12b. KIND OF BUSINESS OR INDUSTRY College	
13a. STATE Maryland			13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2618 Turf Valley Rd. 21043		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Francis Geckle						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Simmons					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 220-98-8564		17. INFORMANT Joseph Geckle			ADDRESS Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8160 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:26x 1 1 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto lost control					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11489 Frederick Rd, Ellicott City, Howard, Md					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Thomas D. Smith				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 1/1/84			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-4-84		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.		
24. FUNERAL DIRECTOR Dzudzinski Funeral Home						25a. DATE REC'D. BY REGISTRAR JAN 3 1984			25b. REGISTRAR'S SIGNATURE John J. Grief		

10-10-50

10-10-50

10-10-50

10-10-50



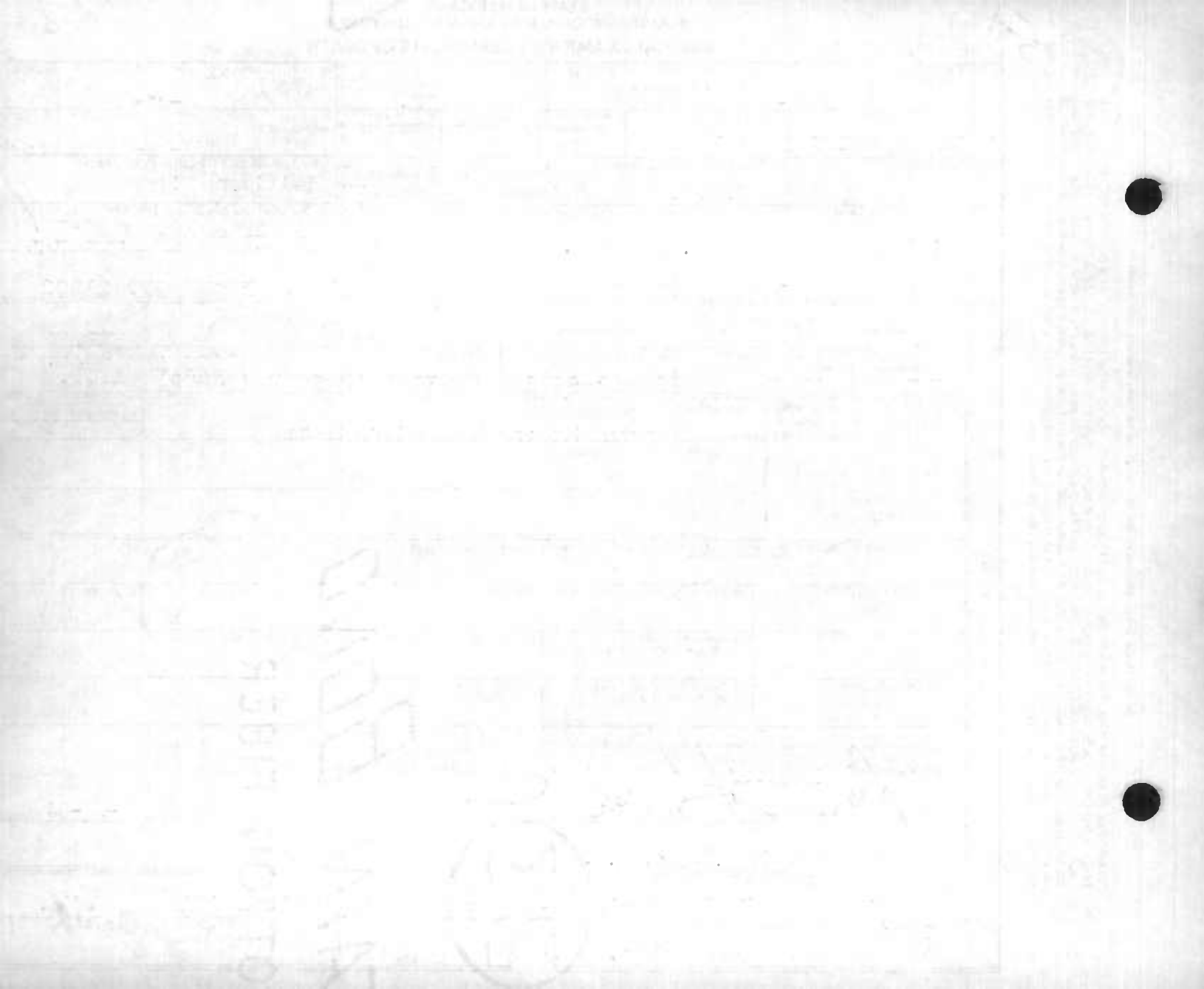
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 00998	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES MERTLIN GEISEY SR.							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-24-84		2b. HOUR M		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 9-13-1898	6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 1-24-84		2d. HOUR 5:44			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 27 S. Exeter St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TOOL & DIE MAKER		12b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED			
13a. STATE MD.		13b. COUNTY -		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 27 S. EXETER ST. 21202			
14. FATHER'S NAME FIRST MIDDLE LAST FRANKLIN GEISEY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GRACE WELLER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW I 218-03-9675		17. INFORMANT ADDRESS LUCILLE ARMIGER (DGHTR) 856 SUE GROVE RD 21221							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Dennis F. Smyth M.D.</u>				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 1-25-84			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/27/84		23c. NAME OF CEMETERY OR CREMATORY Utica Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Utica Mills, Md.			
24. FUNERAL HOME FOR NAME Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213						25a. DATE REC'D. BY REGISTRAR JAN 27 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 4 0 0 9 9 9

1- FOR
STATE
REGISTRAR

CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROSS <i>ROSS</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>1/2/84</i>		2b. HOUR <i>11:10 A</i>	
3. SEX <i>male</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>9 1 10</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>W. Va.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>University of Maryland Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>self emp.</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>real estate</i>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>W. Va.</i>		13b. COUNTY <i>Taylor</i>	
13c. CITY OR TOWN <i>Grafton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>P.O. Box 97 (26354)</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Samuel Gerard</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Manfreda</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>WW 11 236/56/4709</i>		17. INFORMANT ADDRESS <i>Kathleen Gerard (wife) same as 13</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <i>5672</i> IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Multiple system organ failure</i>		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Intraabdominal abscess/sepsis</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>a</i>		

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>10/30/83</i> , 19____, to <i>1/2/84</i> , 19____, that (I) (we) lost saw the deceased alive on <i>1/2/84</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23a. SIGNATURE <i>Malcolm Wilkinson</i>		DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				23c. DATE SIGNED <i>1/2/84</i>	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MALCOLM WILKINSON</i>		23d. ADDRESS <i>University of Maryland Hospital</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6 Jan 84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Grafton Taylor W.Va.</i>	
24. FUNERAL DIRECTOR NAME <i>Singleton Funeral Home, Glen Burnie, MD</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 5 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

100



[Faint, illegible handwritten text covering the majority of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) JENNIE V GERBER					2a. DATE OF DEATH MONTH DAY YEAR January 31, 1984			2b. HOUR 6:30 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec 8, 1894		6. AGE (IN YEARS LAST BIRTHDAY) YRS 89		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garden Village Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3315 Batavia Ave 21214	
14. FATHER'S NAME FIRST MIDDLE LAST Relman W Payne				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Varney					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 215-30-0950		17. INFORMANT ADDRESS Mrs Luciel M Long 8510 Willow Oak Rd 21234			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY 4100 IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Alzheimer's Disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —
19a. DATE OF OPERATION 1/31/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 211/83				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 1/31/84					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 211/83		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1/31/84					
22a. I certify that (I) (the hospital) attended the deceased from 1/31/84 to 2/1/84 , that (I) (we) last saw the deceased alive on 1/31/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) (did not) view the body after death.									22c. DATE SIGNED 2/1/84
22b. SIGNATURE Albert B Bradley				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert B. Bradley, M.D.				22e. ADDRESS 4900 Bel Air Rd. Baltimore, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2/2/84		23c. NAME OF CEMETERY OR CREMATORY Westview		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.				ADDRESS Baltimore, Md.		25a. DATE REC'D BY REGISTRAR FEB 1 1984		25b. REGISTRAR'S SIGNATURE John J. Carver	



January 21, 1934

DEAR

Albino, Inc.

Dear Sirs -

Albino, Inc.

(For Mr. J. H. ...)

Albino, Inc.



Sliver

Very truly yours,

Albino, Inc.

Albino, Inc., 100 ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 1 0 0 1

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ESTELLE E. GERICKE			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 18, 1984		2b. HOUR 5:25PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 2, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, (City) MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital Corp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bus Aide - Handicapped		12b. KIND OF BUSINESS OR INDUSTRY City School	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY --- 13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 422 N. Belnord Ave. 21224.	
14. FATHER'S NAME FIRST MIDDLE LAST John J. Welsh				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie I. Stone			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT 422 N. Belnord Ave. - Baltimore, Mr. Alexander O. Gericke - Md. 21224.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I, (this hospital) attended the deceased from JAN. 6, 19 84 to JANUARY 18, 19 84 that (I (we) first saw the deceased alive on JANUARY 18, 19 84 and that in (my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did (did not) view the body after death.							
22b. SIGNATURE Walker Impagliatelli		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/18/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALKER IMPAGLIATELLI, M.D.		22e. ADDRESS CHURCH HOSPITAL CORPORATION		22f. ADDRESS 100 N. BROADWAY, BALTIMORE, MD. 21231			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/21/84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery - Baltimore, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME John A. Moran, Inc. Funeral Home		24b. ADDRESS 3000 E. Baltimore St., Bto., Md. 21224.		25a. DATE REC'D. BY REGISTRAR JAN 20 1984		25b. REGISTRAR'S SIGNATURE John J. Conner	

BP



100%
COTTON

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 1 0 0 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JANE FRANCES GERVASI			2a. DATE OF DEATH MONTH DAY YEAR 1/17/84		2b. HOUR 734 PM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR NOV. 6 1932	6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TAPE CUTTER		12b. KIND OF BUSINESS OR INDUSTRY GLOVE PROD.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY -	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES STAFFORD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY SIMMONS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 216-28-5111		17. INFORMANT ADDRESS PHILLIP GERVASI (HUSBAND) SAME ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4860 Cordine stroke (b) Due to, OR AS A CONSEQUENCE OF, Respiratory Failure, Hypertensive (c) Due to, OR AS A CONSEQUENCE OF, Pneumonia, Renal Failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Ethanol Abuse, Blood Poisoning					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 1426/83		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1/13/84	
22a. I certify that (I) (we) (hospital) attended the deceased from 1/13/84 to 1/13/84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Schimunek		DEGREE MD		22c. DATE SIGNED 1/13/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Schimunek		22e. ADDRESS c/o Balt City Hosp.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/16/84	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213			25a. DATE REC'D. BY REGISTRAR JAN 17 1984		25b. REGISTRAR'S SIGNATURE John J. Connel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 above any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 1 0 0 3

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Norman William Gettier, Sr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>January 15, 1984</i>			2b. HOUR <i>3:40^{P.}_{M.}</i>				
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>May 16, 1904</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>YRS.</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City, MD.</i>				
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Agnes Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Steel Engraver</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Stationary Supplies</i>		
13a. STATE <i>Md.</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Catonsville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>28 Nunnery Lane, 21228.</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>William E. Gettier</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Viola -- Cecil</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>				16b. SOCIAL SECURITY NO. <i>217-32-9342</i>		17. INFORMANT <i>Mrs. Lila S. Gettier-28 Nunnery Lane</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>VENTRICULAR FIBRILLATIONS</i> <i>4110</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Coronary Insufficiency - (MARKED)</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>8:10</i> P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>1/18/83</i> to <i>1/15</i> 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>1/18/83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Fredrick M.D.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>1/16/84</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>F. KASATIS, M.D.</i>				22e. ADDRESS <i>1801 FREDERICK RD BALTIMORE MD 21228</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>1/18/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>Sterling Funeral Estate, P. A.</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 17 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John E. Cecil</i>				
26. ADDRESS <i>736 Edmondson Ave., Catonsville, Md. 21228</i>										

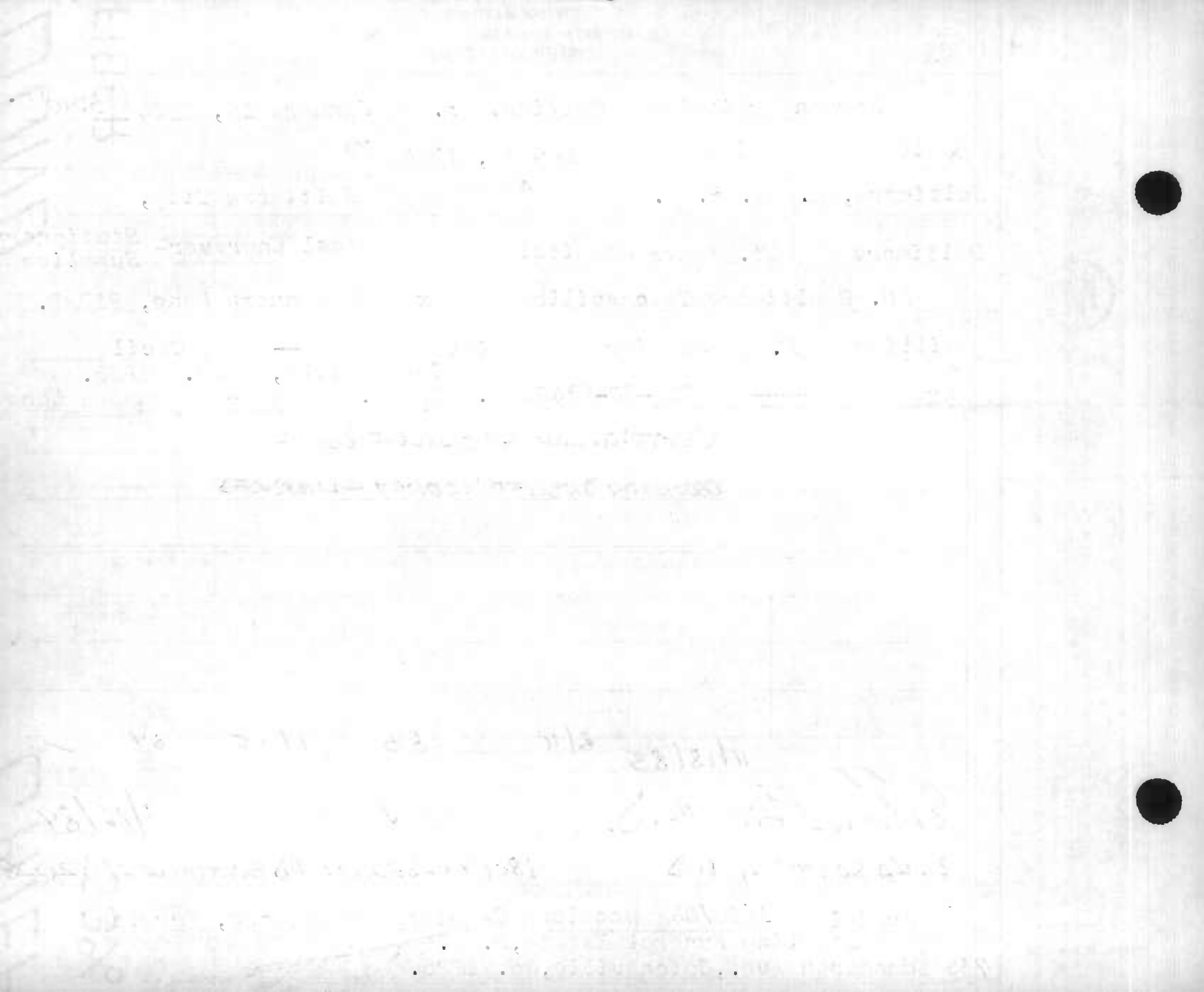
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

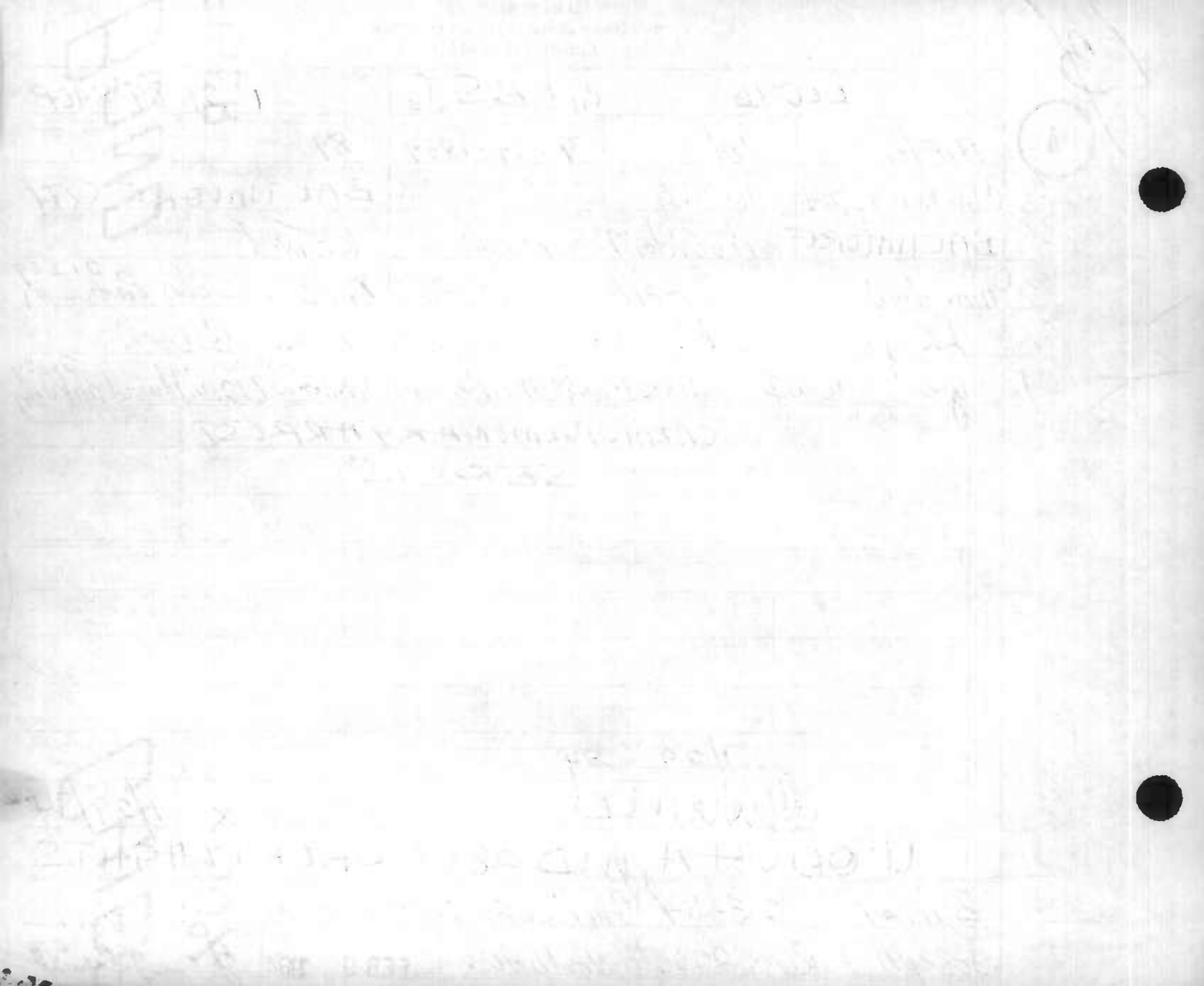
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in my the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 4 and 5 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP





STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ROBERT WAYS GILL			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 1, 1984			2b. HOUR M M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 28, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3607 Greenmount Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3607 Greenmount Ave. 21218	
14. FATHER'S NAME FIRST MIDDLE LAST Roland Ways				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Hampton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-09-7821		17. INFORMANT Audrey V. Gill		ADDRESS Same			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CORONARY ARTERY DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c) **DIABETES MELLITUS**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:

CHRONIC ANEMIA - DIABETIC GASTROPARSIS

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/29 19 83 , to 1/1 19 84 , that (I) (we) last saw the deceased alive on 11/14 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Miguel Karacuschansky				DEGREE M.D.		22c. DATE SIGNED 1-3-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Miguel Karacuschansky, M.D.				22e. ADDRESS 300 E. 33rd St. Baltimore, Md. 21218			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 5, 1984		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto. Co., Md.	
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212				ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR JAN 4 1984	
25b. REGISTRAR'S SIGNATURE John J. Carver							

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

1911

CHRONIC ANEMIA-DIABETIC GASTROENTERITIS

DIABETES MELLITUS

1-3-24

Prof. J. H. Thompson
M.D.

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ESTHER (GILLIARD) GILLARD			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 7 1984			2b. HOUR 1:15 PM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 5 97		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH CHARLES GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Pinkney Lee		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Liza Denny		13e. STREET ADDRESS 401 E. 25th St. Apt. 8D			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) UNKNOWN		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Dorothy Faulkner 401 E. 25th Street Apt. 8D			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS 7070 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DECUBITUS ULCERS DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ASCVD ANEMIA RENAL INSUFFICIENCY							
19a. DATE OF OPERATION 12-27-84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE @ FOOT			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from DEC-15 , 19 83 , to JAN-7 , 19 84 , that (I) (we) lost saw the deceased alive on JAN-7 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C. Vergara-Soares				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-7-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. VERGARA-SOARES				22e. ADDRESS N CHARLES GEN. HOSP. BALT. MD. 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/13/84		23c. NAME OF CEMETERY OR CREMATORY King Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc. 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR JAN 9 1984		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

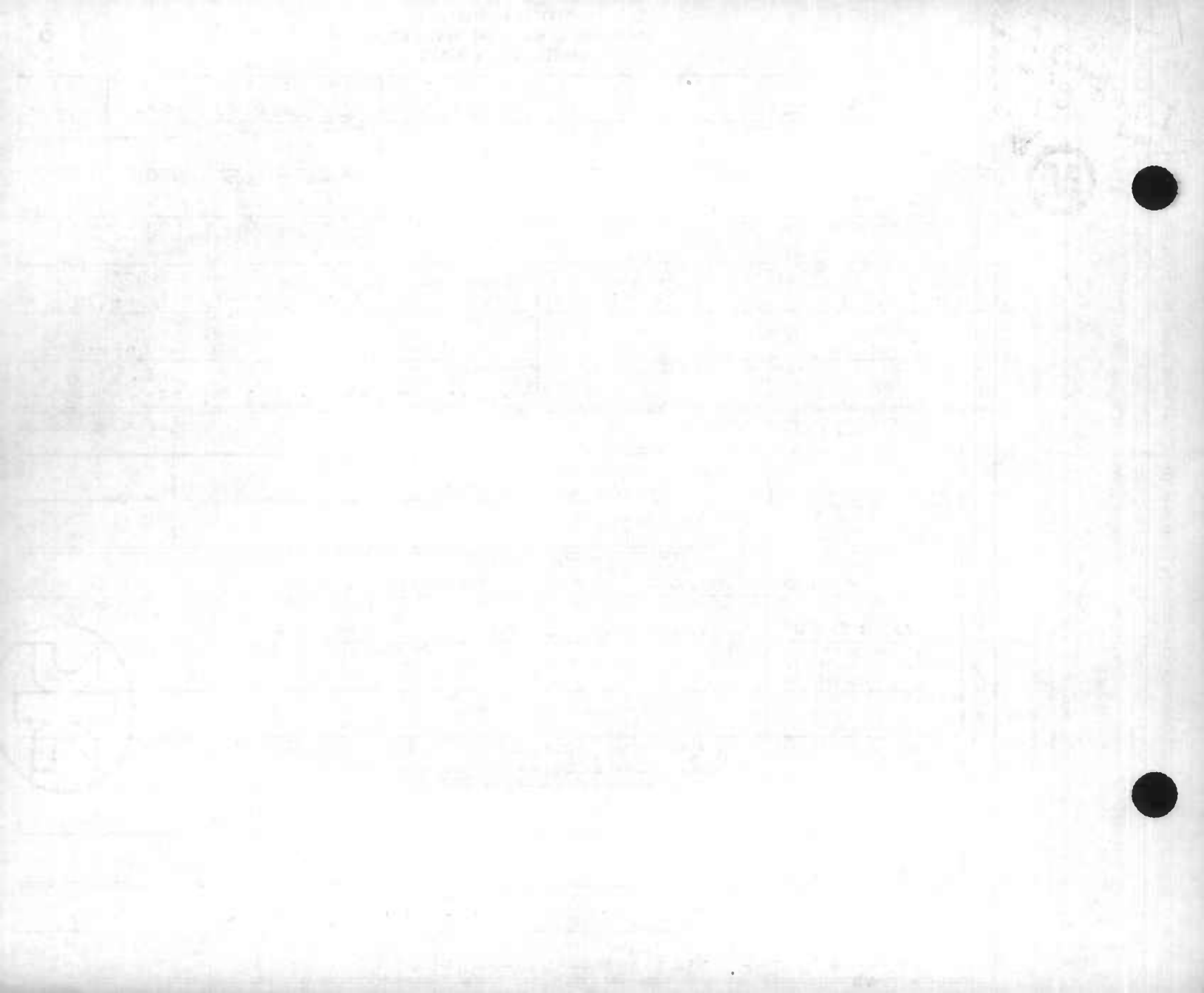
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

BP _____

1 Gold colored band ring found upon middle finger of hand & pt to morgue





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MICHAEL		MIDDLE Bernard	LAST GILLEASE, Jr		2a. DATE OF DEATH		MONTH 1	DAY 22	YEAR 84	2b. HOUR 11:00 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 10 DAY 25 YEAR 14		6. AGE (IN YEARS LAST BIRTHDAY) 69		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Balto. City		12b. KIND OF BUSINESS OR INDUSTRY Police Dept.					
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6004 Alta Ave. 21206					
14. FATHER'S NAME FIRST MICHAEL MIDDLE B. LAST GILLEASE SR.				15. MOTHER'S MAIDEN NAME FIRST LORETTA MIDDLE MURPHY									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-10-2260		17. INFORMANT Mr. Mark Katkowsky				ADDRESS 1807 Crestview Rd. 21239					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC SARCOMA or 1719 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RENAL CELL CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (this hospital) attended the deceased from 1/22 84 1/15 84, to 1/22 84, that (I) saw the deceased alive on above, (I) (did) (did not) view the body after death.													
22b. SIGNATURE L. Ceballos MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/22/84							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. CEBALLOS, MD				22e. ADDRESS GOOD SAMARITAN HOSPITAL									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-24-84		23c. NAME OF CEMETERY OR CREMATORY St. Francis de Salea		23d. LOCATION CITY OR TOWN COUNTY STATE Abingdon, Maryland							
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.				ADDRESS Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR JAN 23 1984		25b. REGISTRAR'S SIGNATURE					

APR 11 1964

GLUCOSE

1000 mg

100

1000 mg

1000 mg

1000 mg

METASTATIC CARCINOMA OF
RENAL CELL CARCINOMA

1000 mg

1000 mg

1000 mg

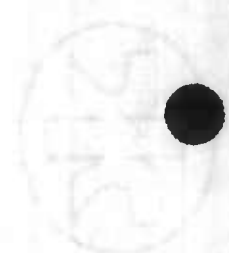
1000 mg

1000 mg

1000 mg

RECEIVED HOSPITAL

RECEIVED MD



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 4 0 1 0 0 8				
1. FOR STATE REGISTRAR					CERTIFICATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST Arthur Ginsberg					MONTH DAY YEAR HOUR 1 30 84 10 ²⁰ a.m.				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		MONTH DAY YEAR 7 4 1910		73		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
USSR		U.S.A.				City MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Sinai Hospital				BREAD WRAPPER		KOESTERS Bakery	
13a. STATE					13b. COUNTY				
Maryland					Baltimore				
13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?				
BALTIMORE					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME (FIRST MIDDLE LAST)					15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)				
Bernard Ginsberg					FANNIE MATZ				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
NO					212-10 6846				
17. INFORMANT					ADDRESS				
Mrs. LENA GINSBERG					3302 KERRY RD. #21207				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Respiratory Cardiac arrest									
5724									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) Renal hepatic and Respiratory fail									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Metastatic liver disease									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
			19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		21g. COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/30/84, 19 84, to 1/30, 19 84, that (I) (we) last saw the deceased alive on 1/30/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE				
Gloria A. Hoff					MD				
22c. DATE SIGNED					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
1/30/84									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
GLORIA A. PRAFIF					7905 Brookford Circle Pikesville MD 21208				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL			JAN. 31, 1984		TZEMECH SEDEK VE SHOMREI HADATH			BALTO. MD	
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR				
SOL LEVINSON & BROS. INC.					FEB 1 1984				
6010 REISTERSTOWN RD. BALTO., MD 21215					25b. REGISTRAR'S SIGNATURE				
					John J. Conish				

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 1 0 0 9

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ralph H Given			2a. DATE OF DEATH MONTH DAY YEAR January 18, 1984		2b. HOUR 6:00^{AM}
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR June 22, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3610 Howard Park Avenue 21207		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore City		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW 1		17. INFORMANT Mrs. Kathryn Given	
		005-05-0716		3610 Howard Park Avenue Baltimore, MD. 21207	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Ventricular ArrhythmiaAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

4140
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic Heart Disease.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Chronic Obstructive Pulmonary Disease.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 5th , 19 83 , to Jan 18th , 19 84 , that (I) (we) lost saw the deceased alive on Jan 17 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.							
22b. SIGNATURE George Taler, M.D.		DEGREE		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Taler, M.D.		22e. ADDRESS 600 Light St. Balt. Md. 21230					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 1-19-84	23c. NAME OF CEMETERY OR CREMATORY Westview Crematory	23d. LOCATION CITY OR TOWN COUNTY Catonsville Baltimore, MD
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc.		25a. DATE REC'D. BY REGISTRAR JAN 19 1984	
25b. REGISTRAR'S SIGNATURE 7. 2. 2. 2.			
26. ADDRESS 8728 Liberty Road Randallstown, MD. 21133			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
2036
2037
2038
2039
2040
2041
2042
2043
2044
2045
2046
2047
2048
2049
2050
2051
2052
2053
2054
2055
2056
2057
2058
2059
2060
2061
2062
2063
2064
2065
2066
2067
2068
2069
2070
2071
2072
2073
2074
2075
2076
2077
2078
2079
2080
2081
2082
2083
2084
2085
2086
2087
2088
2089
2090
2091
2092
2093
2094
2095
2096
2097
2098
2099
2100

2101
2102
2103
2104
2105
2106
2107
2108
2109
2110
2111
2112
2113
2114
2115
2116
2117
2118
2119
2120
2121
2122
2123
2124
2125
2126
2127
2128
2129
2130
2131
2132
2133
2134
2135
2136
2137
2138
2139
2140
2141
2142
2143
2144
2145
2146
2147
2148
2149
2150
2151
2152
2153
2154
2155
2156
2157
2158
2159
2160
2161
2162
2163
2164
2165
2166
2167
2168
2169
2170
2171
2172
2173
2174
2175
2176
2177
2178
2179
2180
2181
2182
2183
2184
2185
2186
2187
2188
2189
2190
2191
2192
2193
2194
2195
2196
2197
2198
2199
2200

2201
2202
2203
2204
2205
2206
2207
2208
2209
2210
2211
2212
2213
2214
2215
2216
2217
2218
2219
2220
2221
2222
2223
2224
2225
2226
2227
2228
2229
2230
2231
2232
2233
2234
2235
2236
2237
2238
2239
2240
2241
2242
2243
2244
2245
2246
2247
2248
2249
2250
2251
2252
2253
2254
2255
2256
2257
2258
2259
2260
2261
2262
2263
2264
2265
2266
2267
2268
2269
2270
2271
2272
2273
2274
2275
2276
2277
2278
2279
2280
2281
2282
2283
2284
2285
2286
2287
2288
2289
2290
2291
2292
2293
2294
2295
2296
2297
2298
2299
2300

2301
2302
2303
2304
2305
2306
2307
2308
2309
2310
2311
2312
2313
2314
2315
2316
2317
2318
2319
2320
2321
2322
2323
2324
2325
2326
2327
2328
2329
2330
2331
2332
2333
2334
2335
2336
2337
2338
2339
2340
2341
2342
2343
2344
2345
2346
2347
2348
2349
2350
2351
2352
2353
2354
2355
2356
2357
2358
2359
2360
2361
2362
2363
2364
2365
2366
2367
2368
2369
2370
2371
2372
2373
2374
2375
2376
2377
2378
2379
2380
2381
2382
2383
2384
2385
2386
2387
2388
2389
2390
2391
2392
2393
2394
2395
2396
2397
2398
2399
2400

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 1 0 1 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	A
TED		Tal	m	GLANCE	JANUARY	31	1984		11:25	A
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.		
Male	White	Dec. 18 1931		52		MONTHS		DAYS		HOURS
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
North Carolina		USA				BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE		THE JOHNS HOPKINS HOSPITAL				Metal Finisher		Gen. Motors		

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS / ZIP CODE
Md.		Baltimore	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	15 Avenal Rd. 21221
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		
FIRST MIDDLE LAST		FIRST MIDDLE LAST		
Unknown		Connie Glance		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
Yes		Korean 242 42 6608		Myrtle A. Glance, Wife Same

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a)	Respiratory / CARDIAC ARREST	
DUE TO, OR AS A CONSEQUENCE OF	(b) Metastatic Spinal Column Cancer	1-2 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	(c) Probable Lung Cancer	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/31, 1983, to 1/31, 1984, that (I) (we) last saw the deceased alive on 1/31, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE	DEGREE	22c. DATE SIGNED	
Bruce Moffatt MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	1/31/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
Moffatt	Hopkins		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	2/4/84	Gaston Memorial Cemetery	Gastonia, Gaston Co., N.C.
24. FUNERAL HOME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Bruzdzinski Funeral Home 1407 Old Eastern Ave. 21221	FEB 1 1984	John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

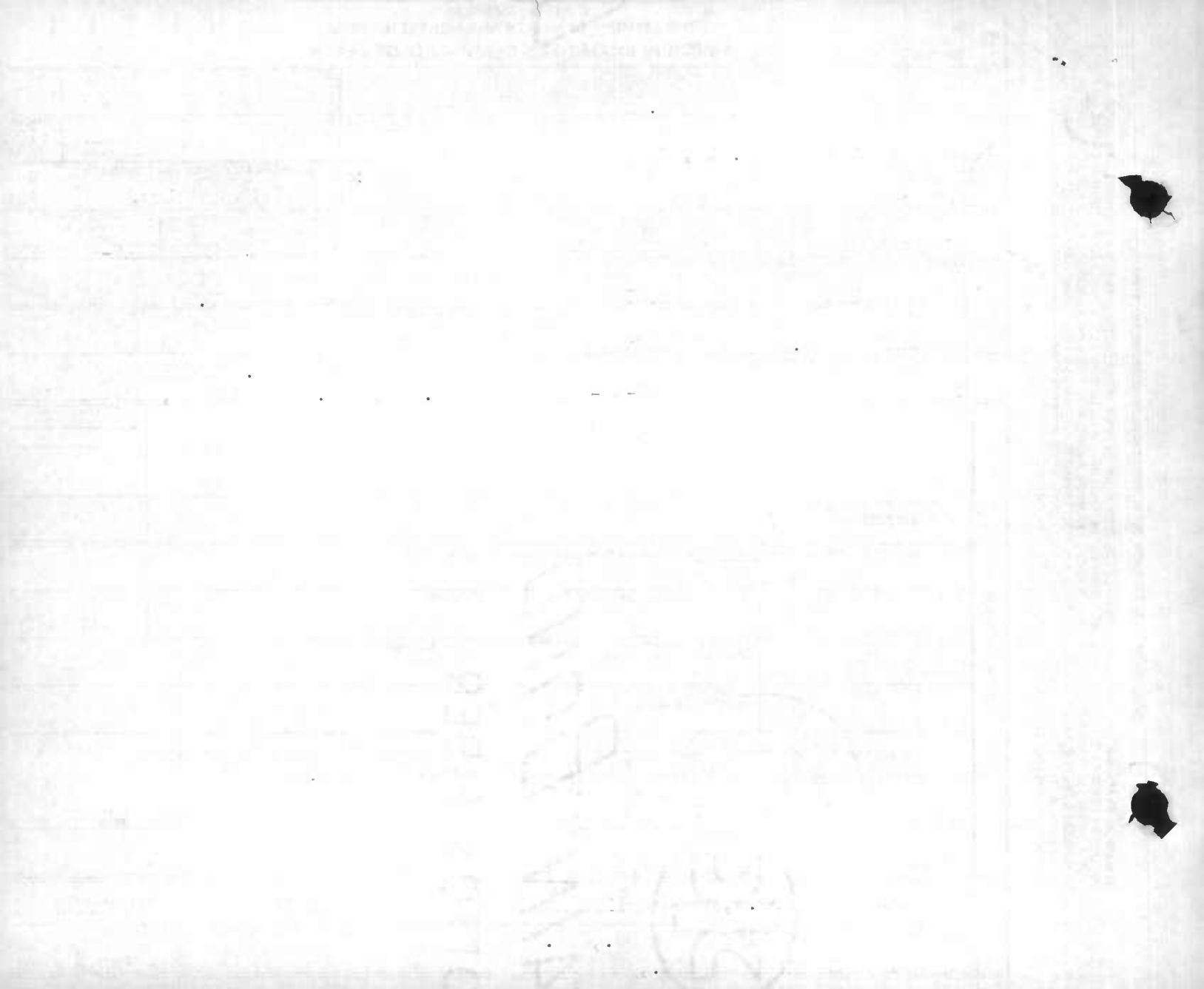
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Robert		W.		Glasner				DATE ESTI-MATED		1		3		1984		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
MALE	WHITE	JAN. 10, 1943		40 YRS.						1		3		1984		5:10A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
MARYLAND		USA		WIDOWED		DIVORCED		Baltimore City,								MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		2631 Cross Country Blvd.		SOCIAL WORKER		SELF-EMPLOYED											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MASSACHUSETTS				BOSTON		YES <input type="checkbox"/> NO <input type="checkbox"/>		37 ANDERSON ST.								99999	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
PHILIP J.		GLASNER		DOROTHY		WARANCH											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		217-40-4475		110 W. 39th St.		BALTIMORE, MD		21210									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART 1 DEATH WAS CAUSED BY:																	
4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
Diabetes mellitus																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
				P.M. 19.													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION									
								CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held of death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
TITLE (SPECIFY)																	
M.D. Deputy Chief MEDICAL EXAMINER																	
ACTUAL SIGNATURE				DATE SIGNED				1/3/84									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Thomas D. Smith, M.D.				111 Penn St.				Balto., MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
BURIAL				JAN. 4, 1984				CHIZUK AMUNO				BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
SOL LEVINSON & BROS., INC.				JAN 5 1984				John J. Smith									
6010 REISTERSTOWN RD BALTO., MD 21215																	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 1 0 1 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RAYMOND E GLOVER.			2a. DATE OF DEATH MONTH DAY YEAR 1-21-84		2b. HOUR 5:40 M
3. SEX M.	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 12 18 19		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Sam. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Agent	12b. KIND OF BUSINESS OR INDUSTRY Insurance	
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Raymond Glover		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beulah Hall			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 234-14-1507	17. INFORMANT ADDRESS Mr. Charles Glover Balto.; Md. 21234		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive Heart Attack 4100 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY Artery Disease and Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Previous 3-MI.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 022		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1-21-84	
22a. I certify that (I) (this hospital) attended the deceased from 1-21-84 , to 1-21-84 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Anil N. Raiker		DEGREE MD.		22c. DATE SIGNED 1/21/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANIL N. RAIKER		22e. ADDRESS GOOD SAMARITAN HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 1/21/84	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JAN 26 1984	
				25b. REGISTRAR'S SIGNATURE John J. Gault	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 1.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETHEL G. GLUCK			2a. DATE OF DEATH MONTH DAY YEAR 1 14 84		2b. HOUR 3:45 AM
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Sept. 19, 1885	6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.		
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KEBMAC		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) registered nurse		12b. KIND OF BUSINESS OR INDUSTRY nursing
13a. STATE Maryland		13b. COUNTY -----	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3838 Roland Ave. 21211
14. FATHER'S NAME FIRST MIDDLE LAST William J. H. Gluck			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucia Jackson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-36-1361A	17. INFORMANT ADDRESS Mrs. Lucia M. Irons 955 Green Rd. Cleveland, Ohio 44121		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain aneurysm</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>senility - Cerebrovascular Disease</u> 5 years DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.					
22b. SIGNATURE G. H. Wiedefeld				22c. DATE SIGNED 1-14-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Jan. 18, 1984	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cem. Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. City Md.
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home			25a. DATE REC'D. BY REGISTRAR JAN 17 1984		25b. REGISTRAR'S SIGNATURE John J. Conner
ADDRESS 6500 York Rd. Bal. Md.					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



20% CO
 CHIT

213-36-1361A Mrs. Lucia M. Irons 955 r	J. H. Gluck	Lucia	3838 Roland Ave.	registered nurse	USA	Sept. 19, 1885	98
	-----	Baltimore	XX			XX	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 1 0 1 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM GOLDEN			2a. DATE OF DEATH MONTH DAY YEAR January 10, 1984			2b. HOUR 6:20a M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 12 16		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTR BALTO MD 21218				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Will Gooden			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Burton			13e. STREET ADDRESS / ZIP CODE 331 East 28th St. 21218			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219 05 5104		17. INFORMANT ADDRESS Ethel Golden 331 East 28th Street				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

4140
IMMEDIATE CAUSE (a)
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) CHRONIC MYOCARDIAL ISCHEMIA

10 yrs.

DUE TO, OR AS A CONSEQUENCE OF

(c) CORONARY ATHEROSCLEROTIC HEART DISEASE

20 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS USED IN CERTAINING CAUSES OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (NATURE OF INJURY IN YEAR REPORT 1 (OR PART 2))			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, CHURCH, PARK, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 14, 1983, to Jan 10, 1984, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Jan 10, 1984, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) NOT view the body after death.							
22b. SIGNATURE Stephen Puentes M.D.		DEGREE		22c. DATE SIGNED 1/11/84		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN Puentes, M.D.		22f. ADDRESS 3900 Loch Raven Blvd. Balto Md 21218					

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 1/14/84		23c. NAME OF CEMETERY OR CREMATORY Md. National Mem Pk. Laurel, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR JAN 12 1984		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

INDEX

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

THE INDEX

1

2

3

4

5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked air item 18 means any injury, or other traumatic event, the medical examiner must be notified at once.

F MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FLORENCE B. GOODMAN						2a. DATE OF DEATH MONTH DAY YEAR 11/7/84			2b. HOUR 6:19 PM		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 5 08		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1240 Rossiter Avenue Apt. 3B 21239			
14. FATHER'S NAME FIRST MIDDLE LAST Taylor Henderson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 219-30-0197		17. INFORMANT ADDRESS Karen Horne 1240 Rossiter Avenue Apt. 3B					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4254 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) END-STAGE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) CARDIOMYOPATHY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 1/2 HRS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from JAN 15, 19 84 to JAN 17, 19 84 , that (we) last saw the deceased alive on JAN 17, 19 84 , and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) viewed the body after death.											
22b. SIGNATURE Madone Kramer				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/17/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. KRAMER				22e. ADDRESS UNION MEMORIAL HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/21/84		23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.					
24. FUNERAL DIRECTOR NAME William C March F/H Inc. 1101 E North Avenue						25a. DATE REC'D. BY REGISTRAR JAN 20 1984		25b. REGISTRAR'S SIGNATURE John J. Conner			

BP

1881



[The remainder of the page contains extremely faint, illegible text and markings, likely bleed-through from the reverse side of the paper.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARY Sophie Goodman			2a. DATE OF DEATH MONTH DAY YEAR 1-23-84 555P			2b. HOUR M M						
3. SEX F		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 11 1899		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.						
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1209-Silverthorne 21239		
14. FATHER'S NAME FIRST MIDDLE LAST William Mitchel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Norris								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-12-0801		17. INFORMANT ADDRESS Winston Banks - SAMP4S 13E						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 0389 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypotension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1-23</u> , 19 <u>84</u> , to <u>1-23</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>1-23</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Jeffrey R. Kirsch MD				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-23-84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey R. Kirsch MD				22e. ADDRESS Good Samaritan Hospital Johns Hopkins Hospital								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1-25-84		23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW			23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Fred. Md				
24. FUNERAL DIRECTOR NAME C. L. Hicks				ADDRESS ANNAPOLIS MD		25a. DATE REC'D. BY REGISTRAR JAN 25 1984			25b. REGISTRAR'S SIGNATURE Sharon G. Coniff			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove co-bonopapers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 21a, any injury, or other traumatic event, the medical examiner must be notified.

Film G593

 3
 Form # 5 7/18/84
 1- STATE REGISTRAR rja

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 4 0 1 0 1 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH GOODMAN			2a. DATE OF DEATH MONTH DAY YEAR 1 12 1984			2b. HOUR MIN 1:30 PM	
3 SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 16 1901		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Suffolk, VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIE TURNER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARITA S. LANGFORD		16. STREET ADDRESS / ZIP CODE 4502 Fairfax Rd. 21207			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 26-120760A		17. INFORMANT ADDRESS DAISY HICKS - 4502 Fairfax Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1719 IMMEDIATE CAUSE (a) (1) Bilobal Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) (2) metastatic Fibrosarcoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY ON ITEM 21b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/10/1984 to 1/12/1984, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Vaywala		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/12/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Vaywala		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-19-84		23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEM		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME BROWN-THOMPSON F.H.		ADDRESS 1913 W. BARTO ST.		25a. DATE REC'D. BY REGISTRAR JAN 17 1984		25b. REGISTRAR'S SIGNATURE John J. Carver	

BP

1:30
1:30
1:30

1:30
1:30
1:30



[Faint, mostly illegible handwritten text across the page, possibly bleed-through from the reverse side.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 1 0 1 8

REG. NO.

1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
			DOROTHY A. GORDON			JANUARY 3, 1984			5:20 AM		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH JAN. 19, 1912			6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
13a. STATE MARYLAND			13b. COUNTY BALTIMORE			13c. CITY OR TOWN RANDALLSTOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST BERNARD KERMISCH			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA UNKNOWN			13e. STREET ADDRESS / ZIP CODE 3716 BRENBROOK DR. #21133					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-46-8439			17. INFORMANT MRS. BARBARA NAIMAN			3716 BRENBROOK DR. RANDALLSTOWN, MD 21133		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 1509 DUE TO, OR AS A CONSEQUENCE OF (b) Esophageal Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 30 days 52 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION 11/28/83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Esophageal Carcinoma			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/21/83 to 1/3/84, that (I) (we) lost saw the deceased alive on 1/3/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE C. Nicholas, MD.			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 1/3/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Nicholas			22e. ADDRESS THE JOHNS HOPKINS HOSPITAL 600 N. WOLFE ST. BALTO. 21205, MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JAN. 4, 1984			23c. NAME OF CEMETERY OR CREMATORY SHAAREI TFILOH			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR JAN 5 1984			25b. REGISTRAR'S SIGNATURE John J. Carver		

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

BP

02:20

12/21

RECEIVED 12/21/2001
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 11 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8401019						
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 1-18-84					2b. HOUR 8:45 AM	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harold Gordon			3. SEX Male		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 8 20 23		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN) OHIO			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore CITY MD.				
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IN NONE IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXECUTIVE			12b. USUAL BUSINESS OR INDUSTRY HEALTH/MENTAL HYGIENE		
13a. STATE MARYLAND					13b. COUNTY Anne Arundel		13c. CITY OR TOWN RIVIERA BEACH		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST BARNEY GORDON					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE MINTZ						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) YES			16b. SOCIAL SECURITY NO. WWII-NAVY 577-26-2526		17. INFORMANT MRS. ELAINE GORDON WIFE RIVIERA BEACH, MD 21122						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4310 Brain death DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral hypoxia DUE TO, OR AS A CONSEQUENCE OF (c) Intercerebral bleed					229 ATLANTA RD.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 1-17-84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intercerebral bleed			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 1-17-84 to 1-18-84, that (I) (we) lost saw the deceased alive on 1-18-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R Samuel Bryant MD					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 1-18-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R Samuel Bryant					22e. ADDRESS 22 S. Green, Baltimore MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JAN. 20, 1984		23c. NAME OF CEMETERY OR CREMATORY BETH JACOB		23d. LOCATION CITY OR TOWN COUNTY STATE FINKSBURG CARROLL MD				
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215					25a. DATE REC'D. BY REGISTRAR JAN 26 1984		25b. REGISTRAR'S SIGNATURE [Signature]				



CHILMARK
100% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copies: Pages 1 and 2 should be filed with the death certificate; Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal; Page 4 should be filed with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examiner's report must be attached to this certificate.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) SELMA IRENE GORDON					2a. DATE OF DEATH MONTH DAY YEAR JANUARY 1, 1984			2b. HOUR 6:55AM			
3 SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAR. 7 1910		6. AGE (IN YEARS LAST BIRTHDAY) 73		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSPITAL CORPORATION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESCLERK			12b. KIND OF BUSINESS OR INDUSTRY -		
13a. STATE VA.		13b. COUNTY -		13c. CITY OR TOWN WEENS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS PO BOX 21 WEEMS, VA. 22482			
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL BAXTER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HATTIE O'SHAUNESSY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 215-30-1859		17. INFORMANT ADDRESS COCKEYSVILLE MD. A LEWIN GORDON -1006 TRICKLING BROOK RD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> 1519 DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC GASTRIC CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21030	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 20, 1983</u> to <u>JANUARY 1, 1984</u> , that (I) (we) last saw the deceased alive on <u>JANUARY 1, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Steve Nelson M.D.</i>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVE NELSON					22e. ADDRESS 100 NORTH CHURCH HOSPITAL BROADWAY 21231						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1/3/84		23c. NAME OF CEMETERY OR CREMATORY Campbells' Presby.			23d. LOCATION CITY OR TOWN COUNTY STATE Kilmarnok Va.			
24. FUNERAL HOME Schimonek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213					25a. DATE REC'D. BY REGISTRAR JAN 3 1984						
25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>											



NAME		ADDRESS		CITY		STATE		COUNTY		ZIP	
J. M. Smith		123 Main St.		Springfield		Ill.		Sangamon		62761	
W. R. Jones		456 Oak Ave.		Chicago		Ill.		Cook		60601	
A. B. White		789 Elm St.		Peoria		Ill.		Peoria		61602	
C. D. Green		101 Pine St.		Bloomington		Ill.		McLean		61701	
E. F. Black		202 Maple St.		Urbana		Ill.		Champaign		61801	
G. H. Brown		303 Cedar St.		Moline		Ill.		Rock Island		61201	
I. J. Taylor		404 Birch St.		Macomb		Ill.		DeKalb		61455	
K. L. Miller		505 Walnut St.		Danvers		Ill.		Franklin		61734	
M. N. Wilson		606 Spruce St.		Normal		Ill.		Tazewell		61764	
O. P. Moore		707 Ash St.		Galesburg		Ill.		Tazewell		61204	
P. Q. Hall		808 Hickory St.		Havana		Ill.		Franklin		61840	
R. S. King		909 Poplar St.		Pontiac		Ill.		Livingston		61761	
T. U. Scott		1010 Sycamore St.		Joliet		Ill.		Will		60431	
V. W. Adams		1111 Chestnut St.		Naperville		Ill.		DuPage		60563	
X. Y. Baker		1212 Elm St.		Aurora		Ill.		DuPage		60009	
Y. Z. Clark		1313 Maple St.		Oak Park		Ill.		DuPage		60454	
Z. A. Evans		1414 Birch St.		Berwyn		Ill.		DuPage		60158	
A. B. Green		1515 Cedar St.		Melrose Park		Ill.		DuPage		60160	
B. C. Hall		1616 Elm St.		Westmont		Ill.		DuPage		60178	
C. D. King		1717 Maple St.		Addicks		Ill.		DuPage		60101	
D. E. Miller		1818 Birch St.		Lisle		Ill.		DuPage		60140	
E. F. Wilson		1919 Spruce St.		Naperville		Ill.		DuPage		60563	
F. G. Moore		2020 Ash St.		Aurora		Ill.		DuPage		60009	
G. H. Taylor		2121 Hickory St.		Oak Park		Ill.		DuPage		60454	
H. I. Scott		2222 Poplar St.		Berwyn		Ill.		DuPage		60158	
I. J. Adams		2323 Sycamore St.		Joliet		Ill.		Will		60431	
J. K. Baker		2424 Chestnut St.		Naperville		Ill.		DuPage		60563	
K. L. Clark		2525 Elm St.		Oak Park		Ill.		DuPage		60454	
L. M. Evans		2626 Maple St.		Berwyn		Ill.		DuPage		60158	
M. N. Green		2727 Birch St.		Melrose Park		Ill.		DuPage		60160	
N. O. Hall		2828 Elm St.		Westmont		Ill.		DuPage		60178	
O. P. King		2929 Maple St.		Addicks		Ill.		DuPage		60101	
P. Q. Miller		3030 Birch St.		Lisle		Ill.		DuPage		60140	
Q. R. Wilson		3131 Spruce St.		Naperville		Ill.		DuPage		60563	
R. S. Moore		3232 Ash St.		Aurora		Ill.		DuPage		60009	
S. T. Taylor		3333 Hickory St.		Oak Park		Ill.		DuPage		60454	
T. U. Scott		3434 Poplar St.		Berwyn		Ill.		DuPage		60158	
U. V. Adams		3535 Sycamore St.		Joliet		Ill.		Will		60431	
V. W. Baker		3636 Chestnut St.		Naperville		Ill.		DuPage		60563	
W. X. Clark		3737 Elm St.		Oak Park		Ill.		DuPage		60454	
X. Y. Evans		3838 Maple St.		Berwyn		Ill.		DuPage		60158	
Y. Z. Green		3939 Birch St.		Melrose Park		Ill.		DuPage		60160	
Z. A. Hall		4040 Elm St.		Westmont		Ill.		DuPage		60178	
A. B. King		4141 Maple St.		Addicks		Ill.		DuPage		60101	
B. C. Miller		4242 Birch St.		Lisle		Ill.		DuPage		60140	
C. D. Wilson		4343 Spruce St.		Naperville		Ill.		DuPage		60563	
D. E. Moore		4444 Ash St.		Aurora		Ill.		DuPage		60009	
E. F. Taylor		4545 Hickory St.		Oak Park		Ill.		DuPage		60454	
F. G. Scott		4646 Poplar St.		Berwyn		Ill.		DuPage		60158	
G. H. Adams		4747 Sycamore St.		Joliet		Ill.		Will		60431	
H. I. Baker		4848 Chestnut St.		Naperville		Ill.		DuPage		60563	
I. J. Clark		4949 Elm St.		Oak Park		Ill.		DuPage		60454	
J. K. Evans		5050 Maple St.		Berwyn		Ill.		DuPage		60158	
K. L. Green		5151 Birch St.		Melrose Park		Ill.		DuPage		60160	
L. M. Hall		5252 Elm St.		Westmont		Ill.		DuPage		60178	
M. N. King		5353 Maple St.		Addicks		Ill.		DuPage		60101	
N. O. Miller		5454 Birch St.		Lisle		Ill.		DuPage		60140	
O. P. Wilson		5555 Spruce St.		Naperville		Ill.		DuPage		60563	
P. Q. Moore		5656 Ash St.		Aurora		Ill.		DuPage		60009	
Q. R. Taylor		5757 Hickory St.		Oak Park		Ill.		DuPage		60454	
R. S. Scott		5858 Poplar St.		Berwyn		Ill.		DuPage		60158	
S. T. Adams		5959 Sycamore St.		Joliet		Ill.		Will		60431	
T. U. Baker		6060 Chestnut St.		Naperville		Ill.		DuPage		60563	
U. V. Clark		6161 Elm St.		Oak Park		Ill.		DuPage		60454	
V. W. Evans		6262 Maple St.		Berwyn		Ill.		DuPage		60158	
W. X. Green		6363 Birch St.		Melrose Park		Ill.		DuPage		60160	
X. Y. Hall		6464 Elm St.		Westmont		Ill.		DuPage		60178	
Y. Z. King		6565 Maple St.		Addicks		Ill.		DuPage		60101	
Z. A. Miller		6666 Birch St.		Lisle		Ill.		DuPage		60140	
A. B. Wilson		6767 Spruce St.		Naperville		Ill.		DuPage		60563	
B. C. Moore		6868 Ash St.		Aurora		Ill.		DuPage		60009	
C. D. Taylor		6969 Hickory St.		Oak Park		Ill.		DuPage		60454	
D. E. Scott		7070 Poplar St.		Berwyn		Ill.		DuPage		60158	
E. F. Adams		7171 Sycamore St.		Joliet		Ill.		Will		60431	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 4 0 1 0 2 1 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) DR. YALE GORDON					2a. DATE OF DEATH MONTH DAY YEAR JANUARY 23, 1984			2b. HOUR 12:45^P	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOV. 14, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DEVELOPER		12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 100 W. UNIV. PKWY. 21210	
14. FATHER'S NAME FIRST MIDDLE LAST DAVID LOUIS GORDON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE IDA FARBER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 265-28-2113		17. INFORMANT MR. RAYMOND GORDON		17a. ADDRESS BALTO., MD		17b. ZIP CODE 21212	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4275 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 Hour									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a CHRONIC RENAL FAILURE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/23 , 19 84 , to 1/23 , 19 84 , that (I) (we) lost saw the deceased alive on 1/23 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jim Greenwald		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jim Greenwald		22e. ADDRESS JOHNS HOPKINS HOSP. - BALTO., MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 25, 1984		23c. NAME OF CEMETERY OR CREMATORY OHEB SHALOM MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN BALTO. MD			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD				25a. DATE REC'D. BY REGISTRAR FEB 1 1984		25b. REGISTRAR'S SIGNATURE John A. Bueh			

BP

فہم

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of a death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 4 0 1 0 2 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) SHIRLEY V GORSULT				2a. DATE OF DEATH MONTH DAY YEAR 1 16 84 2b. HOUR 11 A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 08 20		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO City MD.	
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Agnes Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled-National Instrument Co.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. CITY OR TOWN Baltimore 13c. CITY OR TOWN Owings Mills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 147 Wilgate Road 21117			
14. FATHER'S NAME FIRST MIDDLE LAST Frank Elgert				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 21545308		17. INFORMANT Mr. Lloyd E. Elgert, Jr. ADDRESS 486 Longtowne Court Glen Burnie, MD. 21061			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY 1749 METASTATIC BREAST CARCINOMA IMMEDIATE CAUSE (a) 1749 DUE TO, OR AS A CONSEQUENCE OF (b) 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 1749 DUE TO, OR AS A CONSEQUENCE OF (c) 1749				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1749							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR MARCH 3 19 79 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
21g. certify that (1) this hospital attended the deceased from MARCH 3 19 79 to JANUARY 16 19 84 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated				21h. SIGNATURE Diana H. Griffiths DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22a. PHYSICIAN'S NAME (TYPE OR PRINT) Diana H. Griffiths				22b. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-19-84		23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Maryland	
24. FUNERAL DIRECTOR Loring BYers Funeral Directors, Inc. NAME ADDRESS 8728 Liberty Road Randallstown, MD. 21133				25a. DATE REC'D BY REGISTRAR JAN 17 1984 25b. REGISTRAR'S SIGNATURE John J. Loefer			

BP

SHA 79-09-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completed in the presence of the funeral director. The law also requires that the death certificate be signed by the funeral director and completed in the presence of the attending physician. The law also requires that the death certificate be signed by the funeral director and completed in the presence of the attending physician. The law also requires that the death certificate be signed by the funeral director and completed in the presence of the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the presence of the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ESTHER GOTTLIEB			2a. DATE OF DEATH MONTH DAY YEAR JAN. 21 1984			2b. HOUR 11:55 P.M.				
3. SEX FEMALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR MARCH 17 1904		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) HOLLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GERIATRIC LEVIN & HEISLER CENTER + HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
13a. STATE MARYLAND		13b. CITY BROOKLYN PARK		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 213 W. MEADOW RD.		21225		
14. FATHER'S NAME FIRST MIDDLE LAST JACOB COHEN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MITZI RUBENS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 329-18-9245		17. INFORMANT MR. HARRY H. GOTTLIEB				213 W. MEADOW RD. BROOKLYN PARK, MD 21225	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) METASTATIC BREAST CANCER DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1/25 1984			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from 1/25 19 84 , to 1/25 19 84 , that (we) lost saw the deceased alive on 1/25 19 84 , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.										
22b. SIGNATURE Estrelita O. Ku			DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 1/26/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESTRELITA O. KU			22e. ADDRESS LEVIN & HEISLER GERIATRIC CENTER + HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JAN. 27, 1984		23c. NAME OF CEMETERY OR CREMATORY CHEVRA AHAVAS CHESD		23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN BALTO. MD			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR FEB 1 1984		25b. REGISTRAR'S SIGNATURE [Signature]		

BP

UNITED STATES GOVERNMENT
WASHINGTON, D. C. 20540

3

NOV 03-11-1964 VDM:13110007

FEARLESS

248 34-04-10

COLLECTED: 10/11/64



20% COTTON
FLEXIMIN

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			1 14 84			1:50 AM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
FEMALE			WHITE			MONTH DAY YEAR			73 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
MD			USA						BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE			SOUTH BALTIMORE GENERAL HOSP.			RETIRED			HOMEMAKER		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
MD			GLEN BURNIE						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS					
FIRST MIDDLE LAST			FIRST MIDDLE LAST			7900 BENETTS CIRCLE 21061					
LEONARD			MONROE			SOPHIA			BELT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
NO			214-01-8235			CHART			3001 St Hanover St Balt.		

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4241 IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) CONGESTIVE HEART FAILURE

DUE TO, OR AS A CONSEQUENCE OF

(c) AORTIC STENOSIS

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 1, 11, 19 84, to 4, 14, 19 84, that (1) (we) lost		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
saw the deceased alive on 1, 14, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.		ALfonso A. Ortiz				1-14-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
ALfonso A. Ortiz		3001 South Hanover St Balt. Md.					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		1-17-84		GLEN HAVEN MEM. PRK		GLENBURNIE A.A. Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS		21122 JAN 17 1984		John J. Connel			
McCULLY FUNERAL HOME 3204 MOUNTAIN RD.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above any injury, or other traumatic event, the medical examiner must be notified and autopsy performed.

BP

Handwritten notes and calculations, including a table with columns labeled 'C', 'D', 'E', 'F', 'G', 'H', 'I', 'J', 'K', 'L', 'M', 'N', 'O', 'P', 'Q', 'R', 'S', 'T', 'U', 'V', 'W', 'X', 'Y', 'Z'. The text is mirrored across the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the death certificate. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) BETTY M GRAMS			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 14th 1984		2b. HOUR 8.35A_M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 21, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) Mercy Hospital, Balto. Md.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1449 Patapsco St. Balto. Md. 21230		
14. FATHER'S NAME FIRST MIDDLE LAST Emmer ----- Frome			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie ----- Jones					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-26-1300		17. INFORMANT ADDRESS Mr. William B. Grams, Same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4300 ACUTE CEREBRAL INFARCTION - RIGHT HEMISPHERE DUE TO, OR AS A CONSEQUENCE OF (b) INTRACRANIAL HEMORRHAGE. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) RUPTURED CEREBROVASCULAR ANEURYSM.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from JAN 11th , 19 84 , to JANUARY 14 , 19 84 , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Joseph S. Notarangelo DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-14-1984				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH S. NOTARANGELO M.D.				22e. ADDRESS 301 ST. PAUL PLACE BALTIMORE 21202				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 17, 1984		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME McCully Funeral Home, 130 E. Port Ave. Balto. Md.				25a. DATE REC'D. BY REGISTRAR JAN 17 1984		25b. REGISTRAR'S SIGNATURE John J. Carver		

BP

INFORMATION SHEET



20%
COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18, when any injury, or other traumatic event, or immediate cause of death is notified to the coroner.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST THERESA MIDDLE GRANSEE LAST GRANSEE					2a. DATE OF DEATH MONTH DAY YEAR 1 14 84			2b. HOUR 1.00AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 02 04		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) Good Samaritan Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY home	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3819 Chestnut Rd. 21220	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Miller					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Fisher				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215 40 3194		17. INFORMANT ADDRESS Robert Sylvia 1106 Seneca Rd. 21220					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) Congestive Heart failure									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH since 12/11/83
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/11 , 19 83 , to 1/14 , 19 84 , that (I) (we) last saw the deceased alive on 1/14/84 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23a. SIGNATURE Dr. Huie, M.D.					DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			23c. DATE SIGNED 1/14/84	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) DR. HUIE					23d. ADDRESS GOOD SAMARITAN HOSPITAL				
23e. BURIAL, CREMATION, REMOVAL burial		23f. DATE 1/17/84		23g. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens		23h. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.			
24. FUNERAL DIRECTOR Edzdzinski Funeral Home					25a. DATE REC'D. BY REGISTRAR JAN 17 1984		25b. REGISTRAR'S SIGNATURE John J. [Signature]		

BP

UNITED STATES DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF STAFF
WASHINGTON, D. C.

36

15

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) William B. GRAVES				2a. DATE OF DEATH MONTH DAY YEAR JANUARY 11/84	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 7/13/45	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hosp.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		12c. J.E. Smith	
13a. STATE MD		13b. CITY City		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Gambrill		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Gambrill		13d. STREET ADDRESS / ZIP CODE 514 Mt Holly St, 21229	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-46-8434		17. INFORMANT ADDRESS Ranell Wells 542 S. Paca St. 21230	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 5849 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (c) Acute renal failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Cardio pulmonary arrest with resuscitation					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11/4 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/4 84 to 11 84 , that (I) (we) last saw the deceased alive on 11 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Bernardo D. Smiale		DEGREE MD		22c. DATE SIGNED 11/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bernardo D. Smiale		22e. ADDRESS BON SECOURS HOSPITAL - 2000 W. BALTIMORE ST. BALTO, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-16-84		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.	
24. FUNERAL DIRECTOR NAME Chas.A. Rice FSPA		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD.		25a. DATE REC'D. BY REGISTRAR JAN 19 1984	
25b. REGISTRAR'S SIGNATURE John J. Smith					

1844

B

Handwritten notes and markings on the left margin, including the word "Hand" written vertically.

Handwritten text lines across the top of the page, including "Handwritten" and "Handwritten".

Handwritten text lines across the middle of the page, including "Handwritten" and "Handwritten".

Handwritten text lines across the middle of the page, including "Handwritten" and "Handwritten".

Handwritten text lines across the middle of the page, including "Handwritten" and "Handwritten".

Handwritten text lines across the middle of the page, including "Handwritten" and "Handwritten".

Handwritten text lines across the middle of the page, including "Handwritten" and "Handwritten".

Handwritten text lines across the middle of the page, including "Handwritten" and "Handwritten".

Handwritten text lines across the bottom of the page, including "Handwritten" and "Handwritten".

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 1 0 2 8

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Dorian Gray			2a. DATE OF DEATH MONTH DAY YEAR January 8, 1984		2b. HOUR 7:35 P.M.
3. SEX MALE	4. RACE B LACK	5. DATE OF BIRTH MONTH DAY YEAR 1 8 84		6. AGE (IN YEARS LAST BIRTHDAY) Newborn YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND			13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST LARRY KING			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GAIL GRAY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS BENJAMIN GRAY 3008 THORNDALE	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiorespiratory Arrest**

7650
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Hypoxia**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Severe Immaturity**

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

Prolapsed Cord; Footling Presentation

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from January 8 , 19 84 , to January 8 , 19 84 , that (X) (we) last saw the deceased alive on January 8 , 19 84 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did not) view the body after death.					
22b. SIGNATURE <i>Patricia Saldana</i>				22c. DATE SIGNED 1/9/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patricia Saldana, M.D.				22e. ADDRESS c/o Maryland General Hospital	

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1-13-84	23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK.	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS		25a. DATE REC'D. BY REGISTRAR JAN 13 1984	25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Memorandum

1/13/84

Director, FBI

1-13-84

JM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 0 1 0 2 9

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MAYER		MONTH 1 DAY 19 YEAR 84	
MIDDLE		2b. HOUR 8:10 PM	
LAST GRAY			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
MALE	BLACK	MONTH 1 DAY 4 YEAR 24	59 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	USA		BALTIMORE CITY MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE	LUTHERAN HOSPITAL		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. COUNTY	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS
M.D.	BAK Co.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	619 N. MOUNT ST 17
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		
FIRST MIDDLE LAST	FIRST MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS	
	218-12-0040		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) 1019 CARDIO-PULMONARY ARREST			
DUE TO, OR AS A CONSEQUENCE OF			
(b) CARCINOMA OF LARYNX			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/19/84 to 1/19/84, that (I) (we) last saw the deceased alive on 1/19/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE	DEGREE	22c. DATE SIGNED	
OSWALD	MD	1/19/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
A. OSEI-WUSU	730 ASHBURTON ST BALI, MD 21216		
23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION
BALTI, H.	1-24-84	King Park	BALTI, H.
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
OSWALD, H. 1348	JAN 24 1984	John J. Carver	

BP

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

200% C.C. C.I.

1/2 1/2



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Bythalese Green			2a. DATE OF DEATH MONTH DAY YEAR 1 8 84		2b. HOUR 7¹⁰ A.M.	
3. SEX Female		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 02 19 19		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		
10. CITY OR TOWN OF DEATH Baltimore, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John L. Deaton med. center		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		
14. FATHER'S NAME FIRST MIDDLE LAST FEL DINAND DOUGHY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUSAN LBS LUELLS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 238 32 0313		17. INFORMANT ADDRESS MRS OSALESE MILLARD 2707 CHELSEA TERR		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stage II vulvar carcinoma 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) MODM, CHF, CBS						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from December 23 19 83 , to JAN 8 19 84 , that (I) (we) lost saw the deceased alive on JAN 7 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Wendy Kloesz MD		DEGREE MD		22c. DATE SIGNED 1/8/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wendy Kloesz MD		22e. ADDRESS FHC - U of Md Hosp 225 Greene St				
23a. BURIAL, CREMATION, REMOVAL (CHECK IF) BURIAL		23b. DATE 1-14-84		23c. NAME OF CEMETERY OR CREMATORY TAWCAW Church Cem		
23d. LOCATION CITY OR TOWN COUNTY STATE Summerton S.C.		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE John J. Smith		
24. FUNERAL DIRECTOR NAME ADDRESS JOSEPH L. RUSS 2272 W. NORTH AVE						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

RECEIVED
JAN 10 1955

CHIEF

20% COTTON



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LUILLE GREEN		2a. DATE OF DEATH MONTH DAY YEAR 1/22/84		2b. HOUR 8:25 PM
3. SEX F	4. RACE N 2	5. DATE OF BIRTH MONTH DAY YEAR 10/12/15		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Doc Hicks		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mottie Hicks		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-20-9319		17. INFORMANT ADDRESS Doris Harrison 3312 Woodland Avenue
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest 4371 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction (c) Ischemic CVA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypervolemia, Dehydration, Probable Sepsis				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from Jan 21, 1984 , to Jan 22, 1984 , that (I) (we) last saw the deceased alive on Jan 22, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Elena Barraquer, MD		DEGREE MD		22c. DATE SIGNED 1/22/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Elena Barraquer		22e. ADDRESS SINAI HOSPITAL OF BALTO.		
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 1/27/84	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Anne Arundel Co., Md.	
23d. LOCATION CITY OR TOWN COUNTY				
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc, 1101 E North Avenue		25a. DATE REC'D. BY REGISTRAR JAN 24 1984		25b. REGISTRAR'S SIGNATURE John J. Gough

09-11-2000 10:11

09-11-2000 10:11

09-11-2000 10:11

100

CHIEFLY

200 COL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 4 0 1 0 3 2			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST RACHEL ETTER GREEN				MONTH DAY YEAR HOUR 01-14-84 6.32 P.M.			
3. SEX F Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8-27-98		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hoepital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catoneville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Etter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Sigler		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-34-6272	
17. INFORMANT Mrs. Barbara A. Carbo		1822 Frederick Road -Catonsville, Md.		21228			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1534 IMMEDIATE CAUSE (a) Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic carcinoma, cecum (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1/14/84 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/14/84 to 1/14/84 , that (I) (we) last saw the deceased alive on 1/14/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE William L. Eddelen		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/15/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W J HICKEN		M.D.		22e. ADDRESS St Agnes Hoepital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 1/17/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland	
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A.				25a. DATE REC'D. BY REGISTRAR JAN 19 1984		25b. REGISTRAR'S SIGNATURE [Signature]	
1630 Edmondson Avenue, Catonsville, Md. 21228							



Division of Investigation
 U.S. Department of Justice
 Washington, D.C. 20535
 May 1, 1964
 Mr. J. Edgar Hoover
 Director
 Federal Bureau of Investigation
 Washington, D.C. 20535

Mr. J. Edgar Hoover
 Director
 Federal Bureau of Investigation
 Washington, D.C. 20535

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 4 0 1 0 3 3
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) IDA GREENBERG			2a. DATE OF DEATH MONTH JAN. 28 DAY 1984 YEAR 8:58A.M.		
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH MARCH DAY 11 YEAR 1902	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINAVE HEBREW GERIATRIC CENTER + HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE
13a. STATE MARYLAND		13b. CITY OR TOWN BALTIMORE	13c. STREET ADDRESS 3305 NORTHBROOK RD. #21208		
14. FATHER'S NAME FIRST SAMUEL MIDDLE GREENBERG LAST GREENBERG		15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE BAYLIN LAST BAYLIN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT MRS. HELEN DIENER 3305 NORTHBROOK RD. BALTO., MD 21208	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **PNEUMONIA**
4860
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
CVA, ASCVD, SENILE DEMENTIA

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?
YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (this hospital) attended the deceased from **1/23** 19 **84**, to **1/23** 19 **84**, that (we) last saw the deceased alive on **1/23** 19 **84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.

22b. SIGNATURE
ESTRELITA O. KU

DEGREE **MD**

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED
1/23/84

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ESTRELITA O. KU

22e. ADDRESS
LEVINAVE HEBREW GERIATRIC CENTER - HOSP.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL

23b. DATE
JAN. 24, 1984

23c. NAME OF CEMETERY OR CREMATORY
AITZ CHAIM

23d. LOCATION
CITY OR TOWN **BALTIMORE** COUNTY **MARYLAND** STATE

24. FUNERAL DIRECTOR
NAME **SOL LEVINSON & BROS. INC.**
6010 REISTERSTOWN RD. BALTO., MD 21215

25a. DATE REC'D. BY REGISTRAR
JAN 26 1984

REGISTRAR'S SIGNATURE
Carol

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

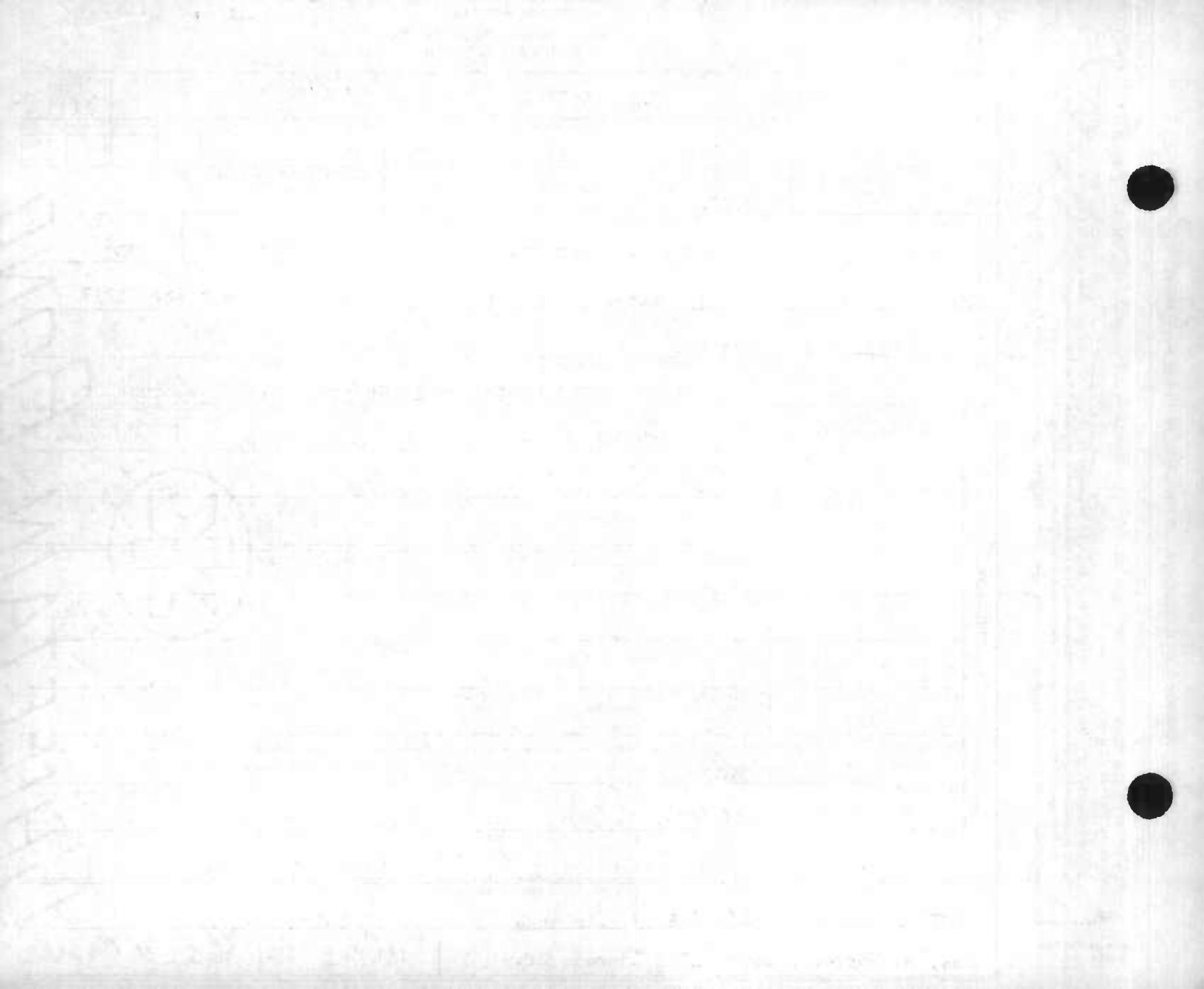
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% CO₂ D₂O

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
EUNICE		G.		GRIFFIN		1/24/84	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		BLACK		MONTH DAY YEAR		83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
VA.		U.S.A.				CITY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		1332 N. Mount St.		Domestic		Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS	
Md.				Balto.		1332 N. Mount St. 21217	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		no		219 32 1570A	
Moses Williams		Stepher		Fitzgerald Stepher		1332 N. Mount St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
PART I. DEATH WAS CAUSED BY:						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
IMMEDIATE CAUSE (a)						20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
4029						YES <input type="checkbox"/> NO <input type="checkbox"/>	
DUE TO, OR AS A CONSEQUENCE OF							
(b)							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED			
		Simon H. Cartwright, M.D.		1/25/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR		22g. REGISTRAR'S SIGNATURE	
Simon H. Cartwright, M.D.		4432 Park Heights Rd		JAN 26 1984		John J. Connel	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		1/28/84		Arbutus		Baltimore Md.	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Jas. A. Morton & Sons		1701 Laurens St.		JAN 26 1984		John J. Connel	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

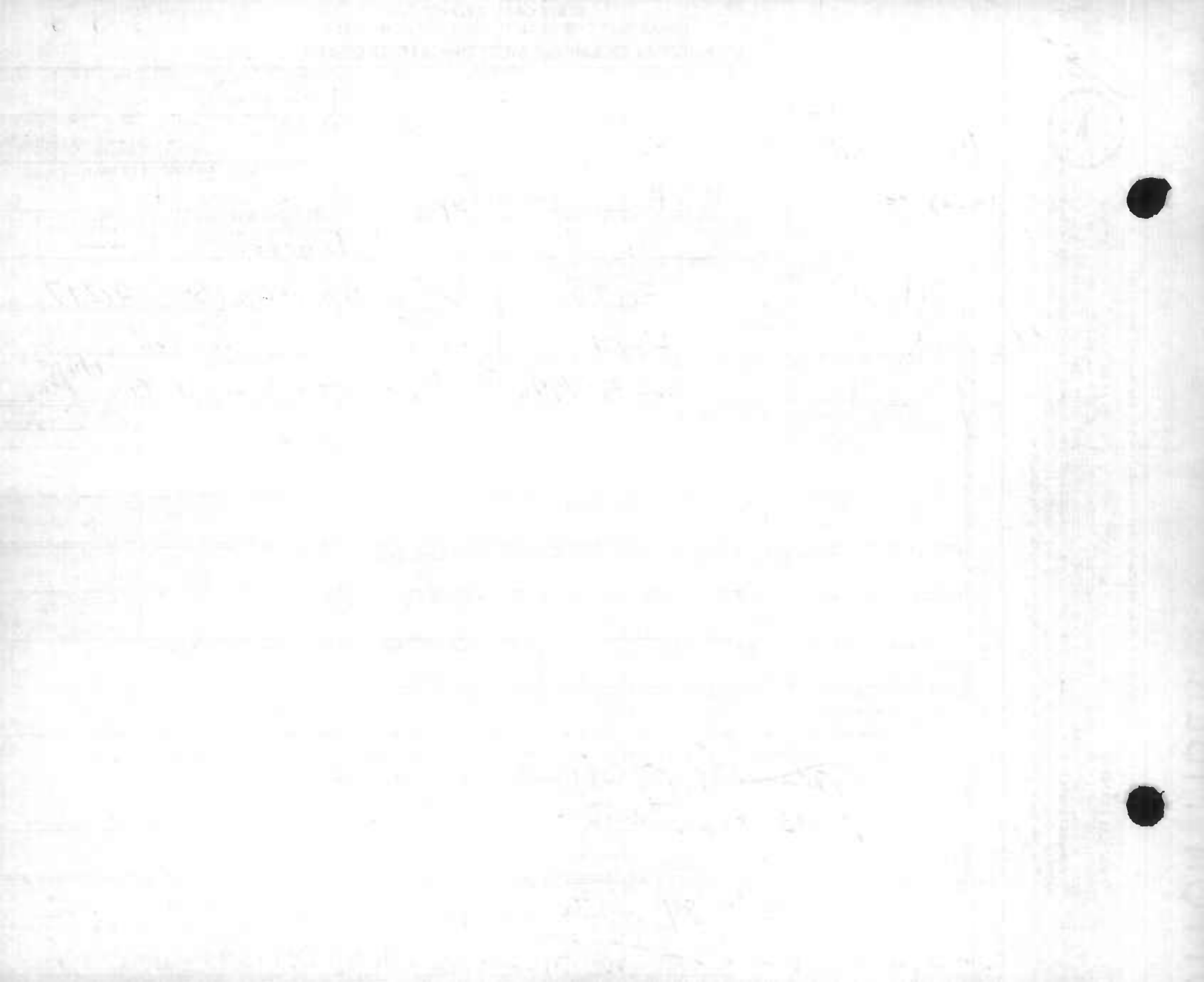
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a copy of the report will be attached to this certificate.

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
ROGER M. Griffith		1 28 84		12 ³⁰ P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. UNDER 1 YEAR	
Male	White	8 4 1904	79 YRS.	MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (COUNTRY)	9. CITIZEN OF WHAT COUNTRY?	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Baltimore City MD		
12. CITY OR TOWN OF DEATH	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	15. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Baltimore City Hospital	Carpenter	Goldseker Real Estate		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	17. CITY OR TOWN	18. INSIDE CITY LIMITS?	19. STREET ADDRESS / ZIP CODE		
Maryland	Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1405 Curie Way 21224		
20. FATHER'S NAME (FIRST MIDDLE LAST)	21. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)	22. ADDRESS			
William Griffith	Effie J. Hood	1405 Curie Way Balto., MD. 21224			
23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	24. SOCIAL SECURITY NO.	25. INFORMANT			
No	218-18-8588	Frances Griffith			
26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.					
IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u>					
5789 DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) <u>sepsis</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) <u>G.I. bleed</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
27a. DATE OF OPERATION		27b. CONDITION FOR WHICH OPERATION WAS PERFORMED		27c. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
28a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		28b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		28c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
29a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		29b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		29c. LOCATION STREET CITY OR TOWN COUNTY STATE	
30a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
30b. SIGNATURE		DEGREE		30c. DATE SIGNED	
John P. Joyce		MD		1/28/84	
31a. PHYSICIAN'S NAME (TYPE OR PRINT)		31b. ADDRESS		31c. DATE REC'D. BY REGISTRAR	
John R. Joyce MD		Balto City Hosp, Balto MD		JAN 31 1984	
32a. BURIAL, CREMATION, REMOVAL (SPECIFY)		32b. DATE		32c. NAME OF CEMETERY OR CREMATORY	
Burial		1/31/84		Gardens Of Faith	
33a. FUNERAL DIRECTOR NAME		33b. ADDRESS		33c. LOCATION CITY OR TOWN COUNTY STATE	
Duda-Ruck, Inc.		7922 Wise Avenue Dundalk, MD. 21222		Baltimore Maryland	
34. DATE REC'D. BY REGISTRAR		34b. REGISTRAR'S SIGNATURE		34c. REGISTRAR'S NAME	
JAN 31 1984		John J. Loefer			

9-01-18-20



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MAMIE Louise GRIMES			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 20, 1984		2b. HOUR 2:48PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR December 1, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laboratory Assistant		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government
13a. STATE Maryland	13b. COUNTY Frederick	13c. CITY OR TOWN Keymar	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 11419 Hill Road Zip: 21757	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Butt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lavinia Baker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT (Son) Pearl A. Grimes Jr., Ijamsville, MD 21754	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Left Ventricular Failure					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs.
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Left Ventricular Aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease SIP Myocardial Infarct					~ 3 mos.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Recurrent Ventricular TACHYCARDIA					
19a. DATE OF OPERATION 1/20/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED LV Aneurysm / Recurrent V. Tach.		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/20 19 83 to 1/20 19 83 , that (I) (we) last saw the deceased alive on 1/20 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE G. Marrone		DEGREE		22c. DATE SIGNED 1/20/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Marrone MD		22e. ADDRESS 600 N. Wolfe St., Balto. Md. Johns Hopkins Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE January 24, 1984		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A., 300 W. Montgomery Avenue, Rockville, MD		25a. DATE REC'D. BY REGISTRAR JAN 25 1984		25b. REGISTRAR'S SIGNATURE John J. Laniel	

BP

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be filed with the 72 hours of death certificate. The funeral director should be notified by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health department death certificate is retained by the hospital or attending physician.

[illegible]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles GROSS			2a. DATE OF DEATH MONTH DAY YEAR 1-31-84		2b. HOUR 6:39 M
3. SEX M.	4. RACE B.	5. DATE OF BIRTH MONTH DAY YEAR MAR 31 1936		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) custodian		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS Hosp.		
12b. KIND OF BUSINESS OR INDUSTRY			13a. STREET ADDRESS / ZIP CODE 1505 Edmondson Ave. 21223		
14. FATHER'S NAME FIRST MIDDLE LAST Louis Gross			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delorse Norman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 212-34-0027		
17. INFORMANT ADDRESS Delorse N. Gross, 1505 Edmondson Ave.					

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIAC ARREST - Intubated shock

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

minutes

DUE TO, OR AS A CONSEQUENCE OF

(b)

Decompensated chronic Cor Pulmonale**years**

DUE TO, OR AS A CONSEQUENCE OF

(c)

Chronic obstructive lung disease**years**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **no**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/31 1984 to 1/31 1984 , that (I) (we) lost saw the deceased alive on 1/31 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE Wm		DEGREE		22c. DATE SIGNED 2/1/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wenceslao F. ALVAREZ		22e. ADDRESS 1940 W. Bath St Baltimore 21223			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2-4-84	23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEM	23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.
24. FUNERAL DIRECTOR NAME BROWN-THOMPSON Fitt		25a. DATE REC'D. BY REGISTRAR FEB 6 1984	25b. REGISTRAR'S SIGNATURE John J. Smith

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Catherine E.			MIDDLE GROVER			LAST			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-14-84			2b. HOUR M						
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Mar. 9, 1932		6. AGE (IN YEARS) LAST BIRTHDAY 51 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 1-14-84		2d. HOUR 11:24									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.									
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 19 S. Highland Avenue, 21224	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Gordon						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Carlile															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-60-9921				17. INFORMANT Thomas Grover, 3411 Gough St. 21224				ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of Skull</u> 8809 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? (HEAD ONLY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 1/14 1984				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject fell down a flight of stairs													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 19 So. Highland Ave. Baltimore, Md.													
22a. I certify that I took charge of the remains desecrated above, and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> MARGARITA A. KORELL, M.D. Assistant MEDICAL EXAMINER DATE SIGNED 1-15-84																					
ACTUAL SIGNATURE				TITLE (SPECIFY) Assistant				DATE SIGNED													
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/18/84				23c. NAME OF CEMETERY OR CREMATORY Wilma Union Chapel Cem				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland									
24. FUNERAL DIRECTOR NAME Joseph N. Zannino, 263 S. Conkling STREET				ADDRESS				25a. DATE REC'D. BY REGISTRAR JAN 20 1984				25b. REGISTRAR'S SIGNATURE									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT MUST BE EXECUTED WITHIN 72 HOURS. IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 19, GIVE PAGES 4, 5, AND 6 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 20, GIVE PAGES 7, 8, AND 9 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 21, GIVE PAGES 10, 11, AND 12 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 22, GIVE PAGES 13, 14, AND 15 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 23, GIVE PAGES 16, 17, AND 18 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 24, GIVE PAGES 19, 20, AND 21 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 25, GIVE PAGES 22, 23, AND 24 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 26, GIVE PAGES 25, 26, AND 27 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 27, GIVE PAGES 28, 29, AND 30 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 28, GIVE PAGES 31, 32, AND 33 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 29, GIVE PAGES 34, 35, AND 36 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 30, GIVE PAGES 37, 38, AND 39 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 31, GIVE PAGES 40, 41, AND 42 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 32, GIVE PAGES 43, 44, AND 45 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 33, GIVE PAGES 46, 47, AND 48 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 34, GIVE PAGES 49, 50, AND 51 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 35, GIVE PAGES 52, 53, AND 54 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 36, GIVE PAGES 55, 56, AND 57 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 37, GIVE PAGES 58, 59, AND 60 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 38, GIVE PAGES 61, 62, AND 63 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 39, GIVE PAGES 64, 65, AND 66 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 40, GIVE PAGES 67, 68, AND 69 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 41, GIVE PAGES 70, 71, AND 72 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 42, GIVE PAGES 73, 74, AND 75 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 43, GIVE PAGES 76, 77, AND 78 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 44, GIVE PAGES 79, 80, AND 81 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 45, GIVE PAGES 82, 83, AND 84 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 46, GIVE PAGES 85, 86, AND 87 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 47, GIVE PAGES 88, 89, AND 90 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 48, GIVE PAGES 91, 92, AND 93 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 49, GIVE PAGES 94, 95, AND 96 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 50, GIVE PAGES 97, 98, AND 99 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 51, GIVE PAGES 100, 101, AND 102 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 52, GIVE PAGES 103, 104, AND 105 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 53, GIVE PAGES 106, 107, AND 108 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 54, GIVE PAGES 109, 110, AND 111 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 55, GIVE PAGES 112, 113, AND 114 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 56, GIVE PAGES 115, 116, AND 117 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 57, GIVE PAGES 118, 119, AND 120 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 58, GIVE PAGES 121, 122, AND 123 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 59, GIVE PAGES 124, 125, AND 126 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 60, GIVE PAGES 127, 128, AND 129 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 61, GIVE PAGES 130, 131, AND 132 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 62, GIVE PAGES 133, 134, AND 135 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 63, GIVE PAGES 136, 137, AND 138 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 64, GIVE PAGES 139, 140, AND 141 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 65, GIVE PAGES 142, 143, AND 144 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 66, GIVE PAGES 145, 146, AND 147 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 67, GIVE PAGES 148, 149, AND 150 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 68, GIVE PAGES 151, 152, AND 153 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 69, GIVE PAGES 154, 155, AND 156 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 70, GIVE PAGES 157, 158, AND 159 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 71, GIVE PAGES 160, 161, AND 162 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 72, GIVE PAGES 163, 164, AND 165 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 73, GIVE PAGES 166, 167, AND 168 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 74, GIVE PAGES 169, 170, AND 171 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 75, GIVE PAGES 172, 173, AND 174 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 76, GIVE PAGES 175, 176, AND 177 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 77, GIVE PAGES 178, 179, AND 180 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 78, GIVE PAGES 181, 182, AND 183 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 79, GIVE PAGES 184, 185, AND 186 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 80, GIVE PAGES 187, 188, AND 189 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 81, GIVE PAGES 190, 191, AND 192 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 82, GIVE PAGES 193, 194, AND 195 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 83, GIVE PAGES 196, 197, AND 198 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 84, GIVE PAGES 199, 200, AND 201 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 85, GIVE PAGES 202, 203, AND 204 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 86, GIVE PAGES 205, 206, AND 207 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 87, GIVE PAGES 208, 209, AND 210 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 88, GIVE PAGES 211, 212, AND 213 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 89, GIVE PAGES 214, 215, AND 216 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 90, GIVE PAGES 217, 218, AND 219 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 91, GIVE PAGES 220, 221, AND 222 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 92, GIVE PAGES 223, 224, AND 225 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 93, GIVE PAGES 226, 227, AND 228 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 94, GIVE PAGES 229, 230, AND 231 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 95, GIVE PAGES 232, 233, AND 234 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 96, GIVE PAGES 235, 236, AND 237 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 97, GIVE PAGES 238, 239, AND 240 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 98, GIVE PAGES 241, 242, AND 243 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 99, GIVE PAGES 244, 245, AND 246 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 100, GIVE PAGES 247, 248, AND 249 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 101, GIVE PAGES 250, 251, AND 252 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 102, GIVE PAGES 253, 254, AND 255 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 103, GIVE PAGES 256, 257, AND 258 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 104, GIVE PAGES 259, 260, AND 261 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 105, GIVE PAGES 262, 263, AND 264 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 106, GIVE PAGES 265, 266, AND 267 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 107, GIVE PAGES 268, 269, AND 270 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 108, GIVE PAGES 271, 272, AND 273 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 109, GIVE PAGES 274, 275, AND 276 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 110, GIVE PAGES 277, 278, AND 279 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 111, GIVE PAGES 280, 281, AND 282 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 112, GIVE PAGES 283, 284, AND 285 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 113, GIVE PAGES 286, 287, AND 288 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 114, GIVE PAGES 289, 290, AND 291 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 115, GIVE PAGES 292, 293, AND 294 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 116, GIVE PAGES 295, 296, AND 297 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 117, GIVE PAGES 298, 299, AND 300 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 118, GIVE PAGES 301, 302, AND 303 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 119, GIVE PAGES 304, 305, AND 306 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 120, GIVE PAGES 307, 308, AND 309 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 121, GIVE PAGES 310, 311, AND 312 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 122, GIVE PAGES 313, 314, AND 315 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 123, GIVE PAGES 316, 317, AND 318 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 124, GIVE PAGES 319, 320, AND 321 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 125, GIVE PAGES 322, 323, AND 324 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 126, GIVE PAGES 325, 326, AND 327 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 127, GIVE PAGES 328, 329, AND 330 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 128, GIVE PAGES 331, 332, AND 333 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 129, GIVE PAGES 334, 335, AND 336 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 130, GIVE PAGES 337, 338, AND 339 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 131, GIVE PAGES 340, 341, AND 342 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 132, GIVE PAGES 343, 344, AND 345 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 133, GIVE PAGES 346, 347, AND 348 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 134, GIVE PAGES 349, 350, AND 351 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 135, GIVE PAGES 352, 353, AND 354 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 136, GIVE PAGES 355, 356, AND 357 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 137, GIVE PAGES 358, 359, AND 360 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 138, GIVE PAGES 361, 362, AND 363 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 139, GIVE PAGES 364, 365, AND 366 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 140, GIVE PAGES 367, 368, AND 369 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 141, GIVE PAGES 370, 371, AND 372 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 142, GIVE PAGES 373, 374, AND 375 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 143, GIVE PAGES 376, 377, AND 378 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 144, GIVE PAGES 379, 380, AND 381 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 145, GIVE PAGES 382, 383, AND 384 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 146, GIVE PAGES 385, 386, AND 387 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 147, GIVE PAGES 388, 389, AND 390 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 148, GIVE PAGES 391, 392, AND 393 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 149, GIVE PAGES 394, 395, AND 396 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 150, GIVE PAGES 397, 398, AND 399 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 151, GIVE PAGES 400, 401, AND 402 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 152, GIVE PAGES 403, 404, AND 405 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 153, GIVE PAGES 406, 407, AND 408 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 154, GIVE PAGES 409, 410, AND 411 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 155, GIVE PAGES 412, 413, AND 414 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 156, GIVE PAGES 415, 416, AND 417 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 157, GIVE PAGES 418, 419, AND 420 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 158, GIVE PAGES 421, 422, AND 423 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 159, GIVE PAGES 424, 425, AND 426 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 160, GIVE PAGES 427, 428, AND 429 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 161, GIVE PAGES 430, 431, AND 432 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 162, GIVE PAGES 433, 434, AND 435 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 163, GIVE PAGES 436, 437, AND 438 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 164, GIVE PAGES 439, 440, AND 441 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 165, GIVE PAGES 442, 443, AND 444 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 166, GIVE PAGES 445, 446, AND 447 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 167, GIVE PAGES 448, 449, AND 450 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 168, GIVE PAGES 451, 452, AND 453 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 169, GIVE PAGES 454, 455, AND 456 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 170, GIVE PAGES 457, 458, AND 459 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 171, GIVE PAGES 460, 461, AND 462 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 172, GIVE PAGES 463, 464, AND 465 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 173, GIVE PAGES 466, 467, AND 468 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 174, GIVE PAGES 469, 470, AND 471 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 175, GIVE PAGES 472, 473, AND 474 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 176, GIVE PAGES 475, 476, AND 477 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 177, GIVE PAGES 478, 479, AND 480 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 178, GIVE PAGES 481, 482, AND 483 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 179, GIVE PAGES 484, 485, AND 486 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 180, GIVE PAGES 487, 488, AND 489 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 181, GIVE PAGES 490, 491, AND 492 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 182, GIVE PAGES 493, 494, AND 495 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 183, GIVE PAGES 496, 497, AND 498 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 184, GIVE PAGES 499, 500, AND 501 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 185, GIVE PAGES 502, 503, AND 504 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 186, GIVE PAGES 505, 506, AND 507 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 187, GIVE PAGES 508, 509, AND 510 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 188, GIVE PAGES 511, 512, AND 513 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 189, GIVE PAGES 514, 515, AND 516 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 190, GIVE PAGES 517, 518, AND 519 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 191, GIVE PAGES 520, 521, AND 522 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 192, GIVE PAGES 523, 524, AND 525 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 193, GIVE PAGES 526, 527, AND 528 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 194, GIVE PAGES 529, 530, AND 531 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 195, GIVE PAGES 532, 533, AND 534 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 196, GIVE PAGES 535, 536, AND 537 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 197, GIVE PAGES 538, 539, AND 540 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 198, GIVE PAGES 541, 542, AND 543 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 199, GIVE PAGES 544, 545, AND 546 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 200, GIVE PAGES 547, 548, AND 549 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 201, GIVE PAGES 550, 551, AND 552 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 202, GIVE PAGES 553, 554, AND 555 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 203, GIVE PAGES 556, 557, AND 558 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 204, GIVE PAGES 559, 560, AND 561 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 205, GIVE PAGES 562, 563, AND 564 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 206, GIVE PAGES 565, 566, AND 567 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 207, GIVE PAGES 568, 569, AND 570 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 208, GIVE PAGES 571, 572, AND 573 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 209, GIVE PAGES 574, 575, AND 576 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 210, GIVE PAGES 577, 578, AND 579 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 211, GIVE PAGES 580, 581, AND 582 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 212, GIVE PAGES 583, 584, AND 585 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 213, GIVE PAGES 586, 587, AND 588 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 214, GIVE PAGES 589, 590, AND 591 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 215, GIVE PAGES 592, 593, AND 594 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 216, GIVE PAGES 595, 596, AND 597 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 217, GIVE PAGES 598, 599, AND 600 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 218, GIVE PAGES 601, 602, AND 603 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 219, GIVE PAGES 604, 605, AND 606 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 220, GIVE PAGES 607, 608, AND 609 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 221, GIVE PAGES 610, 611, AND 612 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 222, GIVE PAGES 613, 614, AND 615 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 223, GIVE PAGES 616, 617, AND 618 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 224, GIVE PAGES 619, 620, AND 621 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 225, GIVE PAGES 622, 623, AND 624 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 226, GIVE PAGES 625, 626, AND 627 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 227, GIVE PAGES 628, 629, AND 630 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 228, GIVE PAGES 631, 632, AND 633 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 229, GIVE PAGES 634, 635, AND 636 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 230, GIVE PAGES 637, 638, AND 639 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 231, GIVE PAGES 640, 641, AND 642 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 232, GIVE PAGES 643, 644, AND 645 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 233, GIVE PAGES 646, 647, AND 648 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 234, GIVE PAGES 649, 650, AND 651 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 235, GIVE PAGES 652, 653, AND 654 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 236, GIVE PAGES 655, 656, AND 657 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 237, GIVE PAGES 658, 659, AND 660 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 238, GIVE PAGES 661, 662, AND 663 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 239, GIVE PAGES 664, 665, AND 666 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 240, GIVE PAGES 667, 668, AND 669 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 241, GIVE PAGES 670, 671, AND 672 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 242, GIVE PAGES 673, 674, AND 675 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 243, GIVE PAGES 676, 677, AND 678 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 244, GIVE PAGES 679, 680, AND 681 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 245, GIVE PAGES 682, 683, AND 684 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 246, GIVE PAGES 685, 686, AND 687 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 247, GIVE PAGES 688, 689, AND 690 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 248, GIVE PAGES 691, 692, AND 693 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 249, GIVE PAGES 694, 695, AND 696 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 250, GIVE PAGES 697, 698, AND 699 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 251, GIVE PAGES 700, 701, AND 702 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 252, GIVE PAGES 703, 704, AND 705 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 253, GIVE PAGES 706, 707, AND 708 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 254, GIVE PAGES 709, 710, AND 711 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 255, GIVE PAGES 712, 713, AND 714 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 256, GIVE PAGES 715, 716, AND 717 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 257, GIVE PAGES 718, 719, AND 720 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 258, GIVE PAGES 721, 722, AND 723 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 259, GIVE PAGES 724, 725, AND 726 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 260, GIVE PAGES 727, 728, AND 729 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 261, GIVE PAGES 730, 731, AND 732 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 262, GIVE PAGES 733, 734, AND 735 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 263, GIVE PAGES 736, 737, AND 738 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 264, GIVE PAGES 739, 740, AND 741 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 265, GIVE PAGES 742, 743, AND 744 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 266, GIVE PAGES 745, 746, AND 747 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 267, GIVE PAGES 748, 749, AND 750 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 268, GIVE PAGES 751, 752, AND 753 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 269, GIVE PAGES 754, 755, AND 756 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 270, GIVE PAGES 757, 758, AND 759 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 271, GIVE PAGES 760, 761, AND 762 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 272, GIVE PAGES 763, 764, AND 765 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 273, GIVE PAGES 766, 767, AND 768 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 274, GIVE PAGES 769, 770, AND 771 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 275, GIVE PAGES 772, 773, AND 774 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 276, GIVE PAGES 775, 776, AND 777 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 277, GIVE PAGES 778, 779, AND 780 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 278, GIVE PAGES 781, 782, AND 783 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 279, GIVE PAGES 784, 785, AND 786 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 280, GIVE PAGES 787, 788, AND 789 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 281, GIVE PAGES 790, 791, AND 792 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 282, GIVE PAGES 793, 794, AND 795 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 283, GIVE PAGES 796, 797, AND 798 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 284, GIVE PAGES 799, 800, AND 801 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 285, GIVE PAGES 802, 803, AND 804 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 286, GIVE PAGES 805, 806, AND 807 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 287, GIVE PAGES 808, 809, AND 810 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 288, GIVE PAGES 811, 812, AND 813 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 289, GIVE PAGES 814, 815, AND 816 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 290, GIVE PAGES 817, 818, AND 819 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 291, GIVE PAGES 820, 821, AND 822 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 292, GIVE PAGES 823, 824, AND 825 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 293, GIVE PAGES 826, 827, AND 828 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 294, GIVE PAGES 829, 830, AND 831 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 295, GIVE PAGES 832, 833, AND 834 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 296, GIVE PAGES 835, 836, AND 837 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 297, GIVE PAGES 838, 839, AND 840 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 298, GIVE PAGES 841, 842, AND 843 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 299, GIVE PAGES 844, 845, AND 846 TO THE FUNERAL DIRECTOR. IN PENCIL IN ITEM 300, GIVE PAGES 847, 848, AND

TO: DIRECTOR, BUREAU OF LAND MANAGEMENT

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]



TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after age 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SALVATORA - GUZZO				2a. DATE OF DEATH MONTH DAY YEAR 01 31 84				2b. HOUR 4:20 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 4, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LOUISIANA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE MD.				13b. COUNTY -		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH CANGELOSI				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSARIA MAGGIO					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-10-1211		17. INFORMANT ADDRESS PAUL GUZZO (SON) 1826 CROMWOOD RD.				21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> <u>1889</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>GENERAL DEBILITATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>BLADDER CANCER</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 20TH</u> 19 <u>84</u> , to <u>JAN 31ST</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>JAN 31ST</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Joel Berezow</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>1/31/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOEL BEREZOW</u>				22e. ADDRESS <u>908 CH 4940 EASTER AVE. BALTIMORE, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/3/84		23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.			
24. FUNERAL DIRECTOR NAME Gellmanek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213				25a. DATE REC'D. BY REGISTRAR FEB 3 1984		25b. REGISTRAR'S SIGNATURE <u>Joel Berezow</u>			

